Coastal Regional Commission of Georgia
Area Agency on Aging

127 F Street | Brunswick, GA 31520
912-262-2800 | www.crc.ga.gov

Area Plan for Aging Services

Planning Cycle
July 1, 2011 to June 30, 2015

Submitted for State Fiscal Year: FY 2012
July 1, 2011 through June 30, 2012
(Revised April 1, 2011)
(Final Approved May 13, 2011)

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March 1, 2011

Dr. James Bulot, Director
Division of Aging Services
#2 Peachtree Street NW
Suite 9-100
Atlanta, GA 30303-3142

Coastal Regional Commission of Georgia
Area Agency on Aging

127 F Street | Brunswick, GA 31520

Dear Dr. Bulot:

The original Area Plan on Aging for the Planning Cycle of July 1, 2011 to June 30, 2015 is hereby submitted on behalf of the Coastal Regional Commission for the period of July 1, 2011 to June 30, 2012.

The Coastal Regional Commission Area Agency on Aging has the authority and responsibility to develop and administer the Area Plan in accordance with all requirements of the Older Americans Act (OAA), State of Georgia and other federal and state programs as appropriate.

This plan reflects meeting all federal and state statutory and regulatory requirements and was approved by the Coastal Regional Commission Council at their meeting held February 9, 2011.

Sincerely,

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_____
AAA Director
Jill Jackson-Ledford

_____
Aging Advisory Council Chairperson
Alberta Mabry

_____
Executive Director
Allen Burns

_____
Council Chairman
Dan Coty

CRC Area Agency on Aging Area Plan Submittal Checklist

Completed by: Rachel Green	**Originally Submitted: February 28, 2011** **Revisions Submitted: April 11, 2011** **Approved: April 21, 2011**			
Indicate Type of Document Submitted:	**Yes**	**No**	**N/A**	**Comments**
Area Plan Cycle Original/Fiscal Year:				
Area Plan Amendment/Fiscal Year:				
Budget Amendment Only/Fiscal Year:				
Area Plan Narrative	**X**			
1) Letter of Intent Signed	**X**			
2) Area Plan Checklist Completed	**X**			
3) Executive Summary	**X**			
Summary Description of Aging Network completed	**X**			
Overview of the Area Agency on Aging completed	**X**			
AAA Roles and Responsibilities	**X**			
AAA Vision, Mission and Values completed	**X**			
Purpose of Area Plan completed	**X**			
4) Context	**X**			
Current and Future Older Persons	**X**			
Needs Assessment Process and Results	**X**			
Gap/barriers/needs to improve existing system	**X**			
Special Needs	**X**			
5) Service Delivery Plan	**X**			
Description of Service Delivery System	**X**			
6) Allocation, Budget and Units Plan				
Allocations Methodology	**X**			
Budget Narrative	**X**			
Indirect Cost Plans	**X**			
Changes to Services/Units/Persons	**X**			
AIMS Area Plan Budget Forms (See attachment E)				

Area Plan Checklist (continued)	Yes	No	N/A	Comments
Attachments				
A) AoA Goals and AAA Objectives Instructions & Charts				
AoA Goal 1	X			
AoA Goal 2	X			
AoA Goal 3	X			
AoA Goal 4	X			
AAA Goal 5 (optional)	X			
B) Location of Services Charts	X			
HCBS	X			
Elder Rights	X			
CCSP	X			
C) Compliance Documents				
Request for Advance/Bond (If applicable)			X	
Standard Assurances	X			
Letter Requesting a Waiver of Standard Assurances	X			
Board Resolution	X			
D) Required Plans	X			
Annual Elder Rights Plan	X			
Long-term Care Ombudsman (LTCO) Annual Plan	X			
Senior Community Service Employment Program			X	
E) AIMS Budget Documents				
Title III Federal Allocation and Match Analysis (Excel)	X			
Area Plan – Budget Fund Source Summary	X			
Area Plan – Budget Service Summary	X			
Area Plan – Provider Site List	X			

Executive Summary

Summary Description of federal, state and local aging network

The foundation of the Aging Network was formalized with the passage of the Older Americans Act of 1965. This legislation was instrumental in defining and creating the beginnings of what we now refer to as the Aging Network. This network has grown considerably through the years, but still includes core organizations such as the Administration on Aging, state Units on Aging, Area agencies on aging and service providers. The US Administration on Aging (AoA) is the federally designated agency that oversees nutrition, home and community based services for older adults and caregivers. AoA is a division of the US Health and Human Services agency. While AoA's main office is located in the DC area, there are regional offices throughout the United States covering the 10 regions. AoA works closely with each state unit on aging to provide vision, funding and regulations for the implementation and operation of aging programs throughout the state. The GA Division of Aging Services (DAS) is designated as the state unit on aging for Georgia. GA division of Aging Services works with Area Agencies on Aging (AAA), regional offices located in each of the 12 regional planning and service areas in GA. The Coastal Regional Commission(CRC) is the designated Area Agency on Aging for the nine-county Coastal Georgia region, offering services in Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Long, Liberty and McIntosh counties. The AAA serves all residents regardless of income, race or national origin. The AAA assesses, plans and coordinates services and programs for senior adults, persons with disabilities, and caregivers of the region. The AAA works with local service providers to operate services at the city and county level. The aging provider network includes city and county governments, non- profit organizations as well as for profit businesses. In order to carry out the aging plan, the AAA works with many consumers, partners and community groups across the region.

The AAA has the responsibility for addressing present and future aging and long-term care issues within Coastal Georgia's growing and diverse communities. Recently, the AAA contracted with Kerr & Downs Research to perform a needs assessment of local adults, 50 years of age and older and caregivers, to develop a demographic trend analysis to effectively estimate the demand for services and activities through the year 2015. Previous work included projections through the year 2030. Results of a separate study commissioned in 2006 by the RDC with the Georgia Institute of Technology, Georgia Coast 2030: Population Projections for the 10-county Coastal Region were also examined. Findings from both studies offer the most recent and comprehensive demographic and service-related data available in the region, providing a strong foundation for future planning and program development for our region's elderly and disabled residents.

This Area Plan reflects the goals, objectives, and activities of the Coastal AAA over the next four-year planning cycle, 2012 through 2015. The Plan is consistent with the Older Americans Act (OAA) legislation and the guidelines set forth by the Georgia Department of Human Services Division of Aging Services (DAS). Most importantly, the Area Plan seeks to inform the general public and regional policymakers of the development and delivery of services designed to foster independence and improve the quality of life for one of our region's most priceless resources – our senior adults.

Overview of the Area Agency on Aging

The Coastal Regional Commission (CRC) was formed in 1964, and has served as the Area Agency on Aging since 1973, providing nine counties and 30 cities with information and access to services for a growing and diverse aging population. Today, the CRC includes Screven County in its Planning and Service Area, however, for Aging programs, Screven continues to be served by the Central Savannah River RC.

The CRC Council serves as the governing body for the organization, and is comprised of thirty-nine (39) county, city, and at-large representatives from across the region. The CRC Executive Director reports directly to the Council and is responsible for the oversight and operations of the organization. In addition to the Aging Services, CRC supports five additional departments, including Administration, Finance, Transportation, Economic Development and Planning and Government Services. Today, the CRC employs thirty-seven professionals and other contract staff.

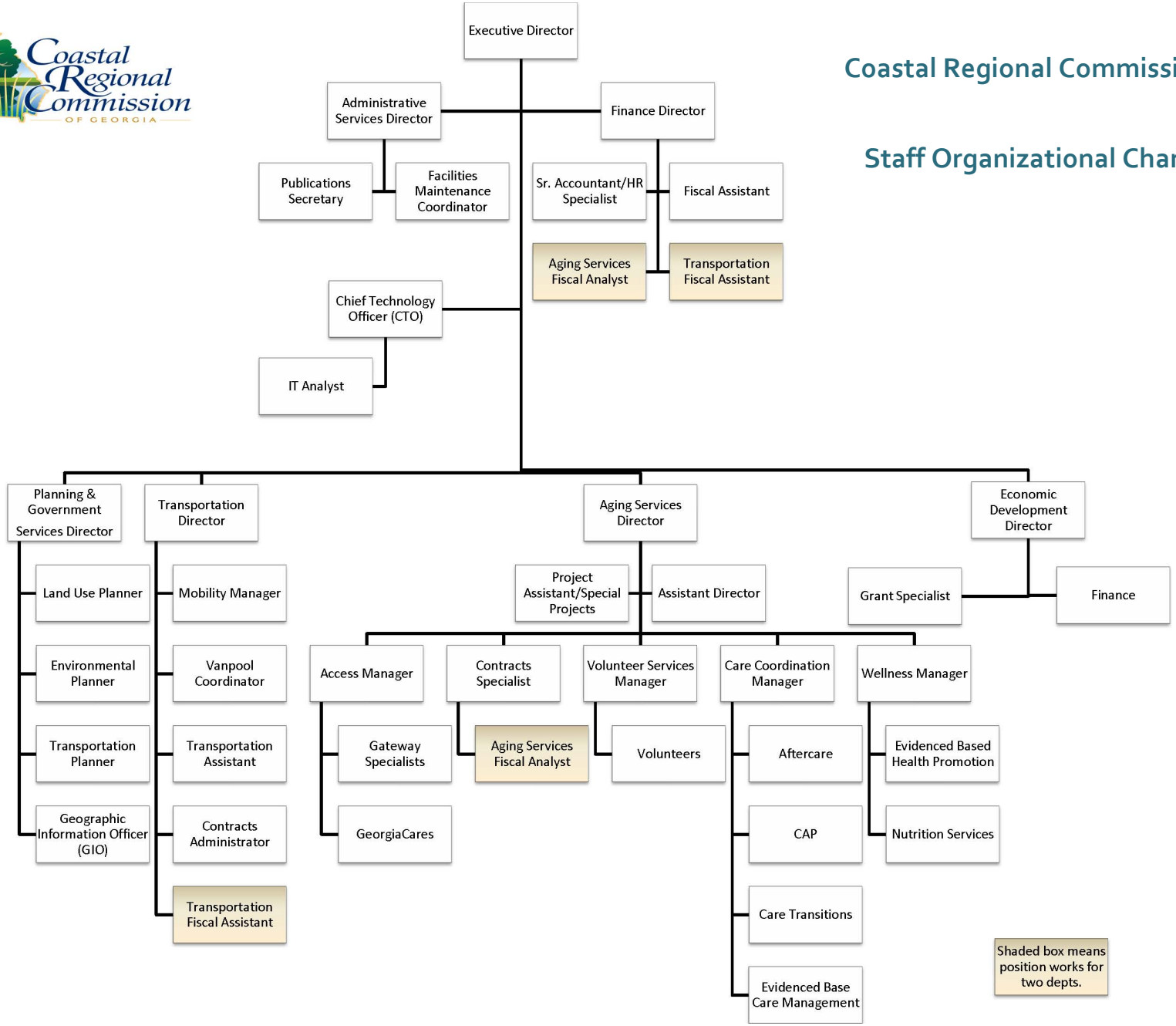
The Coastal AAA has experienced considerable growth over the years, and today employs eighteen individuals and sub-contracts with thirteen organizations to deliver information, programs, and services in a manner consistent with the vision, mission, and values of the organization, the Georgia Division of Aging Services, and the U.S. Administration on Aging. The staff of the AAA consists of a director, 5 lead staff, 12 front line staff and a half time administrative assistant. There are currently three open positions. In addition we leverage other community resources to expand our reach, such as having two SCSEP enrollees as well as a VISTA worker placed in our department. We have recently formalized our volunteer program by hiring a volunteer coordinator to provide oversight and management of volunteers for our agency and providers. Our vision is to grow our pool of 20 some volunteers to 50 or more each year by providing engaging, meaningful assignments for those of all ages interested in volunteering their time and talents. A CRC organizational chart is provided on page 3. The AAA's organizational chart is provided on page 4.

In accordance with the Older Americans Act legislation, the AAA has an Advisory Council made up of three representatives from each county in the region, the majority of whom are over age 60. The Council meets quarterly to review AAA programs and to provide input regarding service and training needs in the region. The Council has an Executive Committee made up of a Chair, Co-Chair, and a Secretary, and operates under established By-Laws. On official matters requiring action, the Council takes a vote and makes its recommendations to the CRC Council for approval.

There are a total of twenty-nine (29) positions on the Coastal Aging Advisory Council, made up of three representatives from each of the nine counties and 2 more representing the City of Savannah. As of this writing, there is one vacancy to be filled. Of the 28 active Council members, 20 are female, 8 are male, and 14 are minorities. The vast majority of members (72%) are retired from a wide variety of professions. One member is on the faculty at Armstrong Atlantic University, one is a former county commissioner of Camden County, 2 work for private businesses, and 3 manage programs in social service or housing organizations.

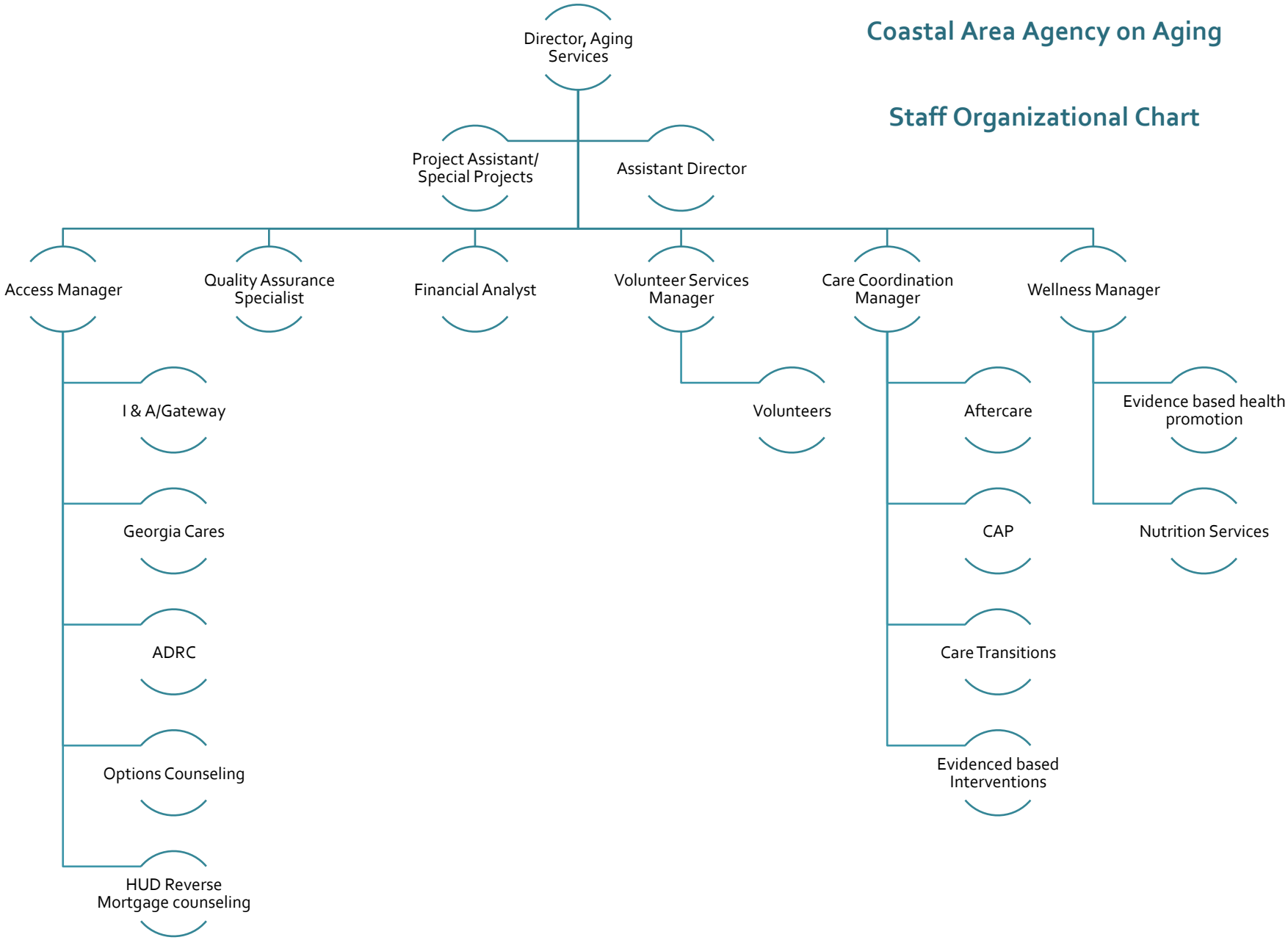
Coastal Regional Commission

Staff Organizational Chart



Coastal Area Agency on Aging

Staff Organizational Chart



AAA Advisory Council Members

Member	County	Past/Current Professional Experience
Annie Mae Golden	Bryan	Not Provided
Eloise Kendrick	Bryan	Not Provided
Lori Gaylor	Bryan	Healthcare
Margie Pevey-Shuman	Bulloch	Higher Education / Business
Roger Branch	Bulloch	Higher Education / Clergy
Julius Abraham	Bulloch	Military/Clergy
Katherine "Nisi" Zell	Camden	Former Elected Official
Ceola Foreman	Camden	Not Provided
Elizabeth Jones	Chatham	Not Provided
Howard Dawson	Chatham	Not Provided
Daisy Mills	Effingham	Not Provided
Rev. Lloyd Dees	Effingham	Faith Community
Linda Mercer	Effingham	Not Provided
Linda Wright	Effingham	Not Provided
Cheryl Meadows-Ussery	Glynn	Social/Aging Services
Beth Boone	Glynn	Elder Law
Miriam Perrone	Glynn	Not Provided
Henry Frasier	Liberty	Government / Clergy
David Anderson	Liberty	Government
Pat Rentz	Liberty	Not Provided
Lillian Simmons	Long	Not Provided
Joyce Williams	Long	Not Provided
Harold Tatum	Long	Not Provided
Sadie Ryals	McIntosh	Education
Alethia Temple	McIntosh	Not Provided
Alberta Mabry	McIntosh	Healthcare
Richard St. Pierre	City of Savannah	Higher Education / Gerontology
Dessie Baker	City of Savannah	Not Provided

AAA roles and responsibilities

The AAA roles and responsibilities are outlined in the Older Americans Act of 1965. These responsibilities include both administrative roles and direct service roles. The administrative responsibilities include conducting a needs assessment of the planning and service area in regard to aging services, program development, coordinating a comprehensive network of services, contracting for the provision of services, training and technical assistance and evaluation. The direct service responsibilities include advocacy, outreach Medicare insurance counseling, case management, information and referral and access, and volunteer management. The following chart outlines the roles and responsibilities of key staff within the AAA.

Title	Summary of Responsibilities
Aging Services Director	This position is responsible for planning, advocacy, coordination, monitoring and administration of the Area Plan and other resources available to the Area Agency on Aging. The Director maintains day-to-day operations of the agency with oversight for 17 + paid and volunteer staff. Ensures the effective coordination of aging services among a network of providers in the nine-county coastal region.
Aging Services Fiscal Analyst	Responsible for the accurate accounting of program funds and preparing financial reports for funding agencies and boards. Analyzes all financial information to know the status of program budgets and funds. Monitors and evaluates the performance of aging contractors and provides technical assistance as needed. Serves as the AIMS Security Administrator, providing access, monitoring and technical assistance to contractors on the use of the data base.
Aging Services Resource Specialist	Responsible for updating and maintaining the ESP database according to the prescribed schedule. Keeps Aging Services staff informed of new resources in the region. Assists with compilation of resource guides. Conducts training in the use of the database. Provides outreach and community education as needed.
Care Coordination Supervisor	Responsible for oversight and supervision of the various case management programs to include Aftercare, TCare, REACH II, CAP. Responsible for the expansion of services including Care Transitions.
GeorgiaCares Coordinator	Responsible for providing information and counseling to individuals with regard to their healthcare and Medicare benefits, including Medicare Part C and Part D. Works closely with ADRC to provide community education and outreach throughout the region. Oversees SMP
GeorgiaCares Assistant	Assists the GeorgiaCares Coordinator with insurance counseling for customers. Provides assistance with filing, intake, referral and reporting for the GaCares, SMP, MIPPA programs.
HCBS Care Manager (3)	Provides information, assistance, and expanded case management services to individuals upon discharge from a hospital or long-term care setting for up to six months, or until the consumer can be admitted to the CCSP or receive other services which promote health and independence in the home setting. Brokers for services using the Direct Purchase of Services (DPS) model. Also provides REACH II and TCare interventions.

Title	Summary of Responsibilities
I&A Program Manager	Responsible for the management and day-to-day operations of the AAA's Gateway Department. Also oversees access to services for Caregivers, the Aging and Disabilities Resource Connection (ADRC), Kinship families (grandparents raising grandchildren) and the Coastal CARE-NET.
Information & Assistance Specialist (7)	Responds to all inquiries regarding access to aging and disability services in the region. Conducts client assessments and gathers other information required to evaluate individual needs for services. Coordinates with other service providers to ensure effective access to care. Conducts follow-up with consumers to determine outcomes as needed. Provides outreach and community education as needed.
Volunteer Services Manager	Provides oversight for volunteer program including recruiting, training, retaining and recognizing volunteers helping with AAA functions and activities. This position works with other departments to manager volunteers.
Nutrition Specialist / Wellness Coordinator	Responsible for monitoring contract nutrition providers for compliance, coordination, and program development for the nine-county region. Provides technical assistance, nutrition education and counseling, conducts health promotion activities, Medication Management activities, health screenings, and outreach which promotes health and wellness for seniors.
Quality Assurance Specialist	Responsible for monitoring and contract compliance for HCBS and CCSP programs, advocacy, coordination, and program development. Also responsible for provider training and emergency preparedness for the coastal aging network.
Special Projects Assistant	Responsible for special projects within the Aging Department. Also acts as liaison with community, public relations, advocacy and disaster preparedness Assists with ongoing staff training and recognition.

Gateway / Aging & Disability Resource Connection (ADRC)

In the role of providing information and access, the AAA services as the regional Aging and Disability Resource Connection (ADRC). The goal of the service is to empower individuals to make informed choices and to streamline access to long term support including a wide range of in-home, community-based and institutional services and programs that are designed to help individuals with disabilities and chronic conditions. The vision is for the ADRC serving as highly visible and trusted place where people can turn for information on the full range of long term support options. The ADRC also serves as a single point of entry for both public and private-pay individuals to public long term support programs and benefits. The ADRC serves older adults, younger adults with disabilities and chronic conditions, family caregivers, as well as persons planning for future long term support needs. In addition, the ADRC is a resource for health and long term support professionals who provide services to the older adults and to people with disabilities.

The ADRC is supported by a strong technology-based infrastructure and a team-based approach for operations

management, trained professionals from multiple functional disciplines provide education, information, assessment, and customized referrals and connections to both private-pay and publicly-supported care options.

An Advisory Committee meeting quarterly provides input, feedback, connection to resources as well as provides outreach for the ADRC. The advisory committee consists of key stakeholders and is co-lead by our partner, Department of Behavioral Health and Development Disabilities (DBHDD). Our partner also is involved in program planning, outreach and decisions regarding the ADRC.

As request for information or services is received, a trained intake specialist is the first contact for a customer. The intake specialist does an initial screening and assigns to a Gateway specialists depending upon the customer's county of origin. The Gateway specialist then contacts the customer to complete the screening for services and/or provides the needed referrals. For customers desiring services, the Determination of Needs Revised (DONR) is completed to further assess the persons need. If the DONR indicates a significant level of need and services are available, referrals are made for services. At this time, if eligible, the Community Care Services Program is explained to the customer. If there is a waiting list for services, the customer is placed on the waiting list along with given appropriate information. If the caller is a caregiver, Gateway specialists also use the TCare screening protocol to determine if a referral to caregiving services is appropriate. Individuals on the waiting list are rescreened every 120 days to identify any changes or needs.

Gateway staff now provide Options Counseling. Options counseling is defined as "an interactive decision-support process whereby consumers, family members, and/or significant others are supported in their deliberations to determine appropriate long-term support choices in the context of the consumer's needs, preferences, values, and individual circumstances." (Lewin Group). In addition Reverse Mortgage Counseling is available for those who are interested in applying for a reserve mortgage. This effort is funded by HUD through the National Council on Aging. The AAA has two trained and certified staff in the ADRC to provide this service.

Gateway staff receive annual and ongoing in service training on topics such as Options Counseling, motivational interviewing, HIPAA, and many other topics to enhance services offered. In addition, Gateway staff are AIRS certified as well as over half the staff have earned a Certificate in Gerontology from Boston University School of Social Work.

The ADRC is responsible for outreach in the community to increase the general publics awareness of the ADRC and services offered. To achieve this, ADRC staff and GeorgiaCares staff participate in community fairs throughout the nine counties on a monthly basis. To supplement these efforts, staff also provide in services to discharge planners, social work departments and similar groups to promote the ADRC.

Other Roles of the AAA

Many of the other roles that the AAA plays centers around representation of and consideration of aging issues in all that we do in the community. The AAA works with other CRC departments to always consider aging issues and integrate in planning. For example in economic development activities, resources for older adults, caregivers and those with disabilities in our communities can be discussed with potential employers as a way to showcase what will be available to their future employees. In addition, attracting retirees to the area should be considered as part of the economic development strategy. For

regional planning, the AAA plays a vital role in the link between planning and developing aging friendly communities. In addition, in assisting local governments with grant applications, the AAA assists by reviewing any grants pertaining to building senior centers, adult day care centers, assisted living facilities and similar projects.

The AAA participates in many committees and advisory groups within the region including groups Healthy Glynn, Family Connections, faith based committees and university sponsored projects. AAA staff also actively participates on statewide boards and committees and are involved in projects through these groups. Pamela Rogers, Quality Assurance Specialist is currently President of the Georgia Gerontological Society. Marvara Green is currently President of Georgia Alliance of Information and Referral Specialists (GAIRS). Jill Jackson Ledford is a member of G4A and currently is leading the senior center association initiative. All of these roles provide for the enhancement of aging service delivery in our region as well as our state.

Working Relationships with Community Organizations

To be successful, the AAA develops and maintains a variety of connections to a large array of community organizations. Many of our partnerships with agencies such as Adult Protective Services, Mental Health, public health and others are forged through participating on one of our many advisory groups. The AAA currently oversees or supports an advisory committee for the ADRC, Wellness and Elder Rights as well as our Aging Advisory Council and the CCSP Network meetings. These groups all have charters or purposes for existing and are have attendees that are appropriate. We involve these agencies in tasks beyond those of advisory groups, such as the recent Request for Proposal review teams. We invited partners from DFCS, public health, extension, banks, university, other agencies etc to participate in the reviews. The purpose was two fold; to help familiarize agencies with the work of the AAA as well as receive input from a different perspective.

The Elder Rights activities are supported by participating in a SALT council (Savannah region) and CAPE (Coalition on Abuse Prevention for the Elderly) (Brunswick area). The AAA participates in both of these organizations to forward the education around abuse, fraud and exploitation. The AAA supports both groups with staff time and funding. As a part of the Elder Rights work, the AAA Gateway staff have a good working relationship with Adult Protective Services. They work closely with APS alerting through reporting when abuse, neglect or exploitation is suspected. The AAA has partnered with these groups to provide events such as the Shred A Thon and educational conferences. Similar events will be planned through the next four year cycle.

The AAA views the older worker as a great source for our community because of the wisdom, skill and work ethic they possess. Because of this value, the AAA provides a training placement for older workers enrolled in the Senior Community Service Employment Program (SCSEP). The AAA currently provides on the job training for two SCSEP enrollees. In addition, the AAA provides space and oversight for a VISTA volunteer who is working on projects that reduce poverty and increase volunteerism.

AAA Vision, Mission and Values

The Area Agency on Aging reviews the mission, vision and value statements for the agency periodically and involves all levels of employees in this process. The CRC has recently started reviewing mission statements for the departments in order to develop one for CRC. A recent staff retreat allowed employees to share their input on the vision of the AAA in order to update it and make it resonate with the customers we serve. Staff previously determined AAA values. Management used staffs' input to update the AAA's mission, vision, and value statements for the FY12 area plan. Our current mission, vision and values are relevant to the AAA responsibilities listed in the Older Americans Act (OAA) and mandated by DAS, as are our priorities.

Our Vision: All seniors, persons with disabilities, and family caregivers residing in Coastal Georgia will have access to information and services that promote physical health, mental well-being and options for living that ensure personal dignity and individual choice.

Our Mission: The mission of the Coastal Georgia Area Agency on Aging is to foster the development of a comprehensive, coordinated system of services which promotes the independence and well-being of coastal area older adults and those with disabilities, and to provide these individuals and their caregivers with information and access to needed services.

Our agency policy and procedures include sound ethical standards and an antifraud policy. Employees are required to complete a Code of Conduct Questionnaire annually and all staff demonstrates conduct consistent with agency ethics and values.

Purpose of Area Plan

Under the Older Americans Act of 1965 as amended, the AAA is responsible for developing a regional plan for aging services to meet the needs of older adults, caregivers and those with disabilities. The purpose of the area plan is to provide a comprehensive and coordinated system of supportive services, nutrition services and senior centers, and the process used to determine the need for supportive services, nutrition services and senior centers within the planning & service area administered by the area agency. The plan describes how the area agency will implement, directly or through contractual or other arrangements, programs and services to meet identified needs within the region in accordance with the plan. Planning efforts and service delivery address the needs of older individuals with greatest economic need and older individuals with greatest social need, including low-income minority individuals, individuals with limited English. In addition, through the development and implementation of the area plan, other agencies and organizations in the Coastal region can identify shared interests and work cooperatively to meet the needs of Coastal Region's older adults, caregivers and those with disabilities.

CONTEXT

Current and future older persons and caregivers

The future needs of Coastal Georgia's elderly population will largely be driven by the rapid population changes that will occur over the next 30 years. The rising numbers of Baby Boomers reaching retirement age along with the growing in-migration to Georgia's coastal areas is expected to significantly impact services to seniors. In order to meet this paramount need, the Area Agency on Aging (AAA) remains committed to building lasting partnerships with organizations, private businesses, and local governments to ensure that our most frail and economically disadvantaged elders receive the care and services necessary to sustain healthy, independent, and dignified lives.

In July 2006, the Coastal Regional Commission commissioned the Georgia Institute of Technology to determine population projections to 2030 for the Coastal region. The impetus for this study was the perception that commonly used projection methods did not adjust for the unique context and most recent growth trends of the Georgia coast. In response to the research, Georgia Coast 2030: Population Projections for the 10-County Coastal Region was published in September 2006. Recognizing the unique conditions of the region, Georgia Tech researchers applied a scientific and context-specific methodology to arrive at population projections by age and sex for each county.

This study recognizes that several factors affect population change, including demographic trends (primarily age distribution and mortality rates), in- and out-migration rates, employment rates and other economic activity, and housing construction. Between 1970 and 2000, the region has shown consistent growth, increasing in population by 62% (approximately 215,600 people). Since 2000, the in-migration rate and strong economic development have continued, and are expected to persist over the next several decades.

Using the Georgia Tech projections, the growth among those aged 55 and over is expected to increase dramatically as demonstrated in the table below:

Coastal Georgia 55+ Projected Population Growth by County							
	2000	2005	2010	2015	2020	2025	2030
Bryan	3,450	6,561	9,794	12,887	15,182	16,669	17,624
Bulloch	9,111	11,363	13,967	16,598	18,660	19,898	20,708
Camden	4,814	7,225	9,981	12,901	15,229	16,819	17,928
Chatham	49,807	61,414	73,034	84,891	94,213	100,482	105,443
Effingham	6,096	8,919	12,355	17,841	21,166	23,539	25,283
Glynn	16,560	21,405	26,247	30,843	34,483	36,981	38,870
Liberty	5,052	6,586	8,257	10,126	11,726	12,813	13,636
Long	1,194	1,649	2,244	2,922	3,683	4,322	4,945
McIntosh	2,512	3,728	4,985	6,144	7,029	7,611	7,933
TOTAL	98,596	128,850	160,864	195,153	221,371	239,134	252,370

Over the next 25 years, the 70 to 79 age cohort will experience the fastest population growth in percentage terms, with the 55 to 59 age cohort experiencing the smallest growth.

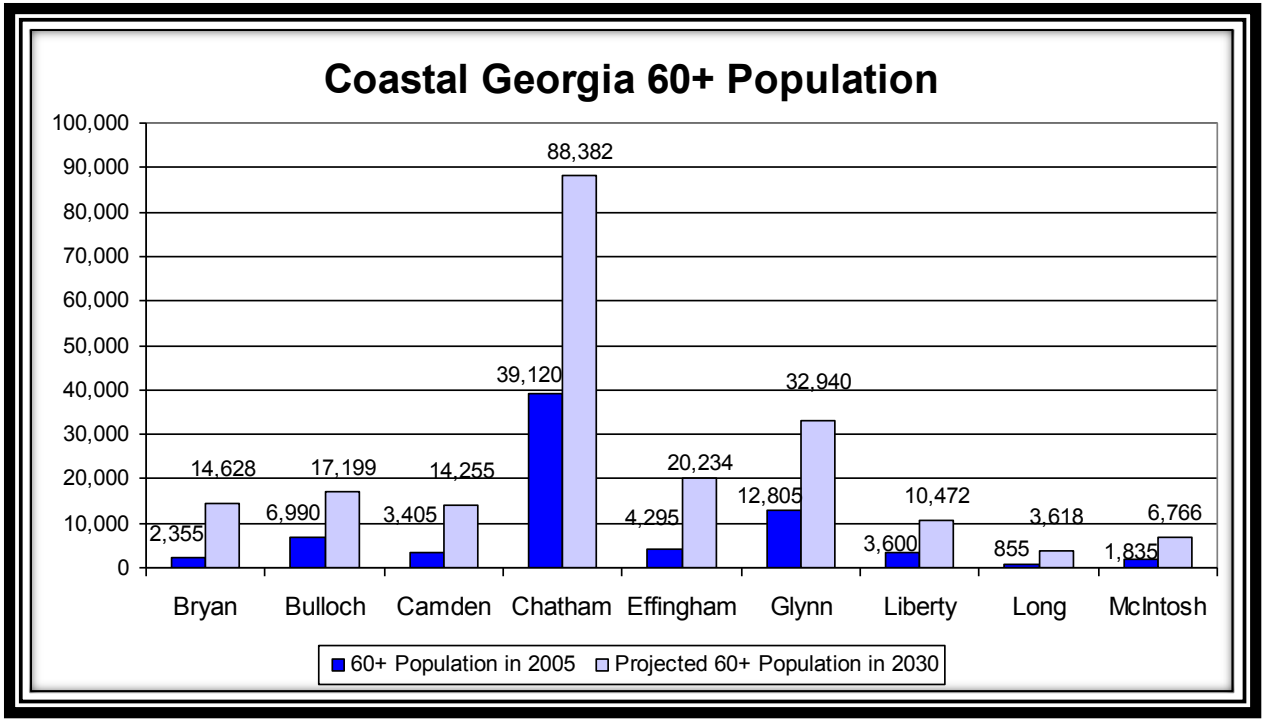
Age Cohort	2005 – 2030 % Population Growth
55 – 59	**30%**
60 - 64	62%
65 – 69	117%
70 – 74	**167%**
75 – 79	162%
80 – 84	134%
80 +	131%

Growth in the Senior Population

This graph reflects data taken from the 2006 study by the Georgia Institute of Technology. The total senior population for Coastal Georgia has reached 75,260. By the year 2030, this number is expected to swell by 277% to 208,494.

While the number of seniors age 60 and over will increase in every county, there will be a shift in where they reside. It is projected that by the year 2030, Chatham County will be home to 42% of the seniors in the region, a drop of almost 10% from 2005. Over the same period, Bryan, Camden, and Effingham Counties will increase significantly in their percentage of coastal elders. The remaining counties will see little change over the next 25 years.

The total senior population for Coastal Georgia has reached 75,260. By the year 2030, this number is expected to swell by 277% to 208,494.



Poverty Among Coastal Georgia Seniors

Aging in America brings concerns about economic security during old age. Although the poverty rate for the elderly is much lower today than thirty years ago, growing old and the cost of health care jeopardizes the economic security of the elderly. Specifically, the rising cost of long term health care has a great impact on the risk of the elderly being poor. According to the U.S. Census, the poverty rate for elderly women is approximately twice the poverty rate of elderly men and the poverty rate of elderly blacks and Hispanics are more than twice the poverty rate of elderly whites in the United States.

According to Census 2000, approximately 12.8% of older adults in the coastal area are considered at or below the poverty level. In counties such as Liberty (19.9%) and Long (19.8%), nearly 1 in 5 seniors aged 65 or older are at or below the federal poverty level. Those in the relatively urban counties of Chatham and Glynn fare best: in Chatham, only 11.5% of elders fall into that category, and in Glynn, 11.9% of elders are impoverished. Not surprisingly, a much higher percentage of African-Americans than Caucasians aged 65 and over are poor. The disparity between the two races is particularly evident in Effingham County, where 45.3% of African-Americans are below poverty as compared to 7.81% of Caucasians in the county. Long County is the only exception to this trend, where 14.6% of African-Americans are impoverished in contrast to 22.7% of Caucasians.

The table below provides the Census 2000 data for poverty rates in each of the nine Coastal Georgia counties.

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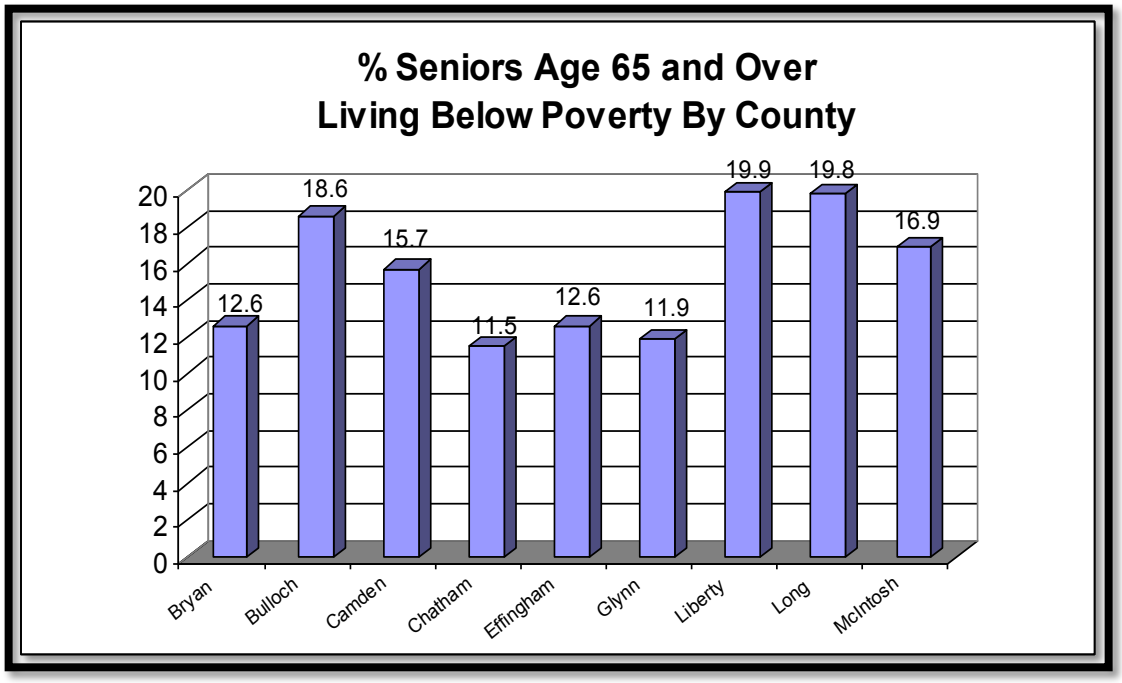


The following data and trends analysis was taken from a study and needs assessment completed in the Coastal region in 2010 by researching firm, Kerr & Downs.

Only 1% of residents over 55 years of age living in the Coastal Georgia region admitted they will not be able to make it financially for the rest of their lives. Over seven in ten residents (71%) were either in good shape financially or thought that they would be alright. Two in ten individuals (19%) were concerned about their ability to make ends meet for their rest of their lives.

	Financially, I am in good shape for the rest of my life	Financially, I may be OK for the rest of my life, but I'm not totally sure	Financially, I am concerned about my ability to make ends meet	Financially, there is no way I'm going to make it	Not sure
Total	29%	42%	19%	1%	9%
Bryan	23%	51%	13%	2%	11%
Bulloch	33%	47%	11%	3%	6%
Camden	30%	57%	9%	0%	4%
Chatham	32%	43%	19%	1%	5%
Effingham	30%	53%	5%	0%	13%
Glynn	35%	37%	20%	1%	7%
Liberty	37%	27%	16%	1%	19%
Long	20%	49%	32%	0%	0%
McIntosh	28%	48%	13%	0%	11%

This table shows the total household income, including social security, retirement, investments, work, etc. for the typical resident over 55 years of age living in the Coastal Georgia region.

	Less than $650 per month	$650 - $899 per month	$900 - $1,599 per month	$1,600 - $1,800 per month	More than $1,800 per month
Total	28%	6%	15%	8%	45%
Bryan	36%	2%	18%	3%	43%
Bulloch	36%	3%	14%	5%	43%
Camden	21%	1%	15%	6%	59%
Chatham	29%	6%	11%	8%	47%
Effingham	22%	5%	14%	8%	53%
Glynn	27%	1%	18%	11%	44%
Liberty	24%	4%	17%	4%	53%
Long	25%	8%	17%	17%	34%
McIntosh	23%	14%	15%	0%	49%

Racial/Ethnic and Low-Income Population by County

According to the *Georgia State Plan on Aging FY2008 – 2011*, Coastal seniors age 60 and over made up 13% of all Georgia's elderly living at or below the poverty level. Data from Census 2000 provides information about the elderly minority population living below poverty in the Coastal region.

Persons 65+ with Limited Mobility

The impact of limited mobility among the elderly and others with disabilities places an enormous burden on one's capacity to remain independent at home and in the community. This problem is especially difficult for those residing in rural areas where public transportation is unavailable. Individuals unable to drive their own vehicles due to advanced age and/or disabling condition must rely on others to get to the doctor, pharmacy, grocer, church, or visit with friends and family. As a result, these individuals are at increased risk for disease, malnutrition, depression, and isolation.

In Coastal Georgia there are 10,727 seniors age 65 and over with mobility impairments (Census 2000). Not surprisingly, the largest numbers of mobility-impaired elderly reside in the most populous counties – Chatham, Bulloch, and Glynn. However, only one county, Chatham, has a public transportation system, leaving nearly half (46%) of all mobility-impaired residents in the region without access to goods, healthcare, and services, thereby increasing their risk for institutionalization.

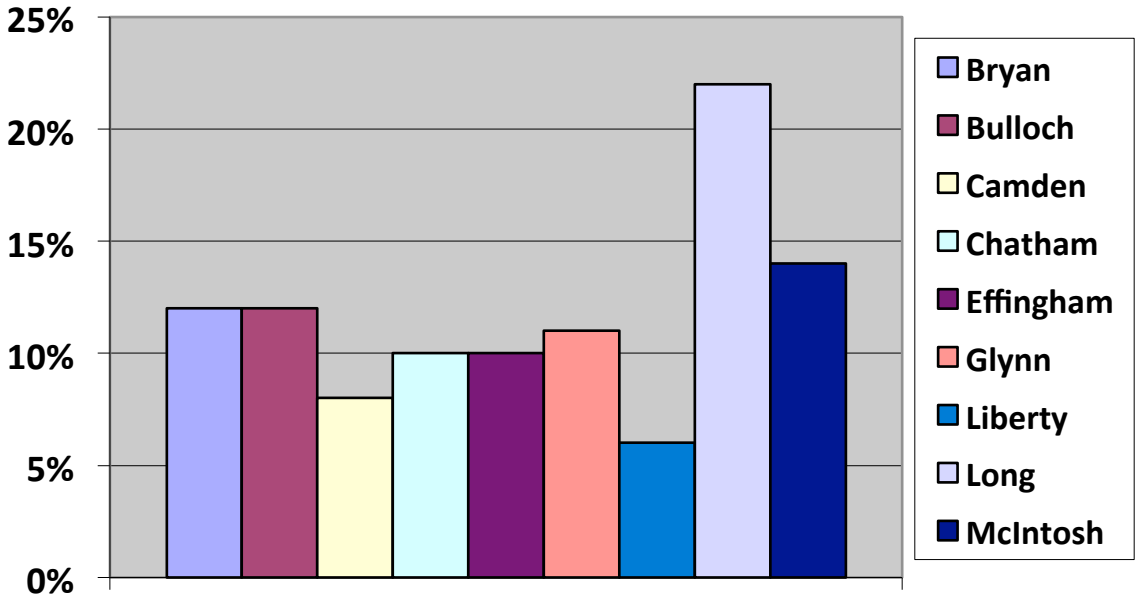
Disabled Persons Under 60

Like most organizations serving the elderly today, the Coastal AAA is increasingly working with elders who have disabling conditions and/or are responsible for other family members, including their own adult children, with disabilities. Identifying and accessing needed resources is especially difficult for these individuals, who frequently need assistance and supportive services for themselves and a loved one across multiple social agencies. Coordinating public benefits and services for families with a variety of self-help needs can best be delivered when services are managed through a single entity.

The Coastal Area Agency on Aging is able to provide information and access to needed services to any Coastal resident with long-term care needs, whether due to age or disability. Consequently, the AAA is considered a "one-stop-shop" for families seeking resources and assistance in their local communities.

Caregivers: Persons Age 55+

This graph shows the percentage of persons age 55+ that are primary caregivers for someone who needs assistance with everyday activities such as bathing, feeding, dressing, eating, and other personal needs.



One in eight residents (12%) function as the main helper or care giver for someone who needs assistance with everyday activities. This percentage ranged from 6% in Liberty County to 22% in Long County. Three in ten caregivers (29%) claimed they need assistance or a break from their care giving responsibilities. A majority of the care givers (61%) who want a break from their responsibilities would like someone else to perform personal care and grooming to the person for whom they have been caring. Three in five care givers (58%) also want some emotional support for themselves. Nearly half of caregivers also desire transportation assistance for the person they care for and they desire that someone be available to talk to the person and do things with the person they normally care for. A majority of care givers (65%) wanted someone to help them administer care from time-to-time to the person they typically help. About half of the care givers also wanted someone else to help them with household tasks and meal preparation.

Not quite half of the care givers (48%) reported feeling burdened from providing care to another person. Most of the caregivers who felt burdened experienced these feelings daily.

Nutrition / Health: Persons Age 55+

The Coastal Area Agency on Aging contracted with Kerr & Downs to conduct the Demographics and Trends Analysis and Elder Needs Assessment. The study examined physical and mental health needs, personal and home-related needs, nutritional and dietary needs, social and recreational needs, and financial needs and self-sufficiency. This was conducted in 2010. Over nine out of ten residents (95%) living in the Coastal Georgia region are able to get enough fresh fruits and vegetables. All residents in Liberty County are able to do so, while residents in McIntosh County (91%) are least likely to get enough fresh fruits and vegetables. Just over nine out of ten residents (92%) are physically able to prepare their own food. All residents in Camden and Glynn Counties are able to do so, while fewer than nine out of ten residents in Long (86%), Chatham (87%), and McIntosh (89%) counties are able to prepare their own food.

Nearly half of residents (47%) in the Coastal Georgia region suffered from diabetes, hypertension, cancer, arthritis or some other on-going condition. Incidence of one of these on-going conditions was greatest in Liberty (54%), Effingham (53%), and McIntosh (53%) counties, and lowest in Bulloch (29%) and Bryan (31%) counties. Because younger residents were included in the 2010 study, fewer individuals compared to 2006 experienced impaired vision (12%), ambulatory difficulty (11%), and significant hearing loss (9%). Over four in ten individuals (42%) experienced none of the conditions. Incidence of hearing loss was higher in Liberty (22%) and Glynn (19%) counties; incidence of ambulatory difficulties was higher in Glynn County (20%); and impaired vision was more prevalent in Liberty County (21%).

Needs Assessment Process and Results

The needs assessment process began with identifying the information staff need in order to plan for a 4 year cycle. After this information was determined, the AAA contracted with a marketing and research firm to conduct a scientific telephonic survey of 1,000 55+ individuals in the coastal region. The firm worked with the AAA to finalize the questions which resulted in a 15-20 minute phone conversation. The study was conducted via random digit telephone interviewing during the month of June 2010. The sampling error for binomially distributed data given a 95% confidence level is 3.1 percentage points.

The study examined physical and mental health needs, personal and home related needs, nutritional and dietary needs, social and recreational needs and financial needs and self-sufficiency. Comparisons to a similar study conducted in 2006 are made throughout the report where appropriate. It should be noted that the 2006 study utilized a different data collection method and focused more on elders who already used many of the community resources available for older adults, indigent and disadvantaged persons. The 2010 study has a representative sample of all people who are over the age of 55 living in the coastal Georgia region. Results of the 2010 study are reflective of the needs of all people 55 and older rather than only the needs of elders who are already accessing community resources through various agencies, organizations, churches and local government. The survey results were summarized in August 2010 and presented to various stakeholder groups such as the Aging Advisory Council, the Community Care Services networking group, the CRC Council. The results were also discussed at both Public Hearings held in October and November 2010. The results of the needs assessment along with customer satisfaction surveys and other feedback received during the year were used in determining and refining the needs of older adults, disabled adults and caregivers for the region. In addition, staff reviewed information on state and national trends in aging services to determine areas to target for future growth as well as trends to integrate into AAA operations.

Some of the recommendations included:

- Invest time in documenting and determining the regions aggregate capabilities to serve those who need services
- Identify gaps between capability to serve and needs
- Prioritize funding/resources needs
- Better publicize AAA efforts
- 58% have a health issue - need more programs to assist in self care or dealing with chronic conditions as well as access to healthcare

- 13% have obstacles in maintaining good mental health (or 24,732 people by 2015) – Need to develop programs and partnerships to target this need.
- 24% indicate they have emotional problems (or 45,660 people by 2015) – need to develop programs and partnerships to deal with these issues
- 43% say they will volunteer 5 hours a week which equates to 400,000 + volunteer hours per week – need to develop easy access for these people to "plug into the system" as well as provide good support and engaging opportunities. This significant resource of volunteerism can be used to provide solutions for the other needs.
- 31% have experienced house- related problems, such as caring for a house inside or out, trouble paying housing expenses or need of home modifications.
- 14% surveyed would like to receive assistance(transportation, errands, support group, homemaker, etc. of those, half are willing to pay for the assistance – Need to match volunteers up with those in need as well as consider developing more fee for service programs
- 57% want to participate in "sponsored activities" such as one would find at a senior center, community center or YWCA/YMCA. This equals 108,441 people by 2015. The sponsored activities need to be relevant, available and accessible – This finding indicates a need to review current senior center operations and determine a plan to increase relevancy to new generations of older adults.
- Of the caregivers surveyed, 50% were stressed 100% of the time – This finding indicates the need to expanded caregiver services and interventions.
- Of the 5% that placed a family member in an institution over the last year, 74% would have liked to talked to a trained professional before placement and over half would have paid for the service. This finding indicates the need for options counseling as well as further exploration of fee for service.

The profile of the survey respondent showed that the median age is 65 (compared to 73 in 2006), 45% male, 55% female and 64% were married. The majority of respondents live with one other person (55%) and 42% live alone. Overall, the respondents have been residents of the region for a long time. Thirty-five percent have lived in the region from 21-40 years, 24% have lived in the region for 11-20 years. Sixty-five percent of the respondents are Caucasian, 32% are African American, 4% are Hispanic, Asian, Pacific Islander or other. To find out about what is going on in their area 61% relied on newspapers, 54% on television, 36% talking with friends and family, 30% internet and 27% radio. Only 11% cited brochures as a way of getting information, so organizations need to revisit the use of brochures to reach potential customers.

Gaps, Barriers and Improvements Needed for Existing Aging Services

Based on the 2010 Elder Needs Assessment and Demographic Trends Analysis, information gathered at public hearings, feedback gathered from client surveys, input from the Coastal Advisory Council and contracted providers, analysis of client ESP/CHAT records, and upon review of monthly AAA waiting list reports, there remain several serious gaps and barriers within the existing service system which prevent the AAA from achieving its vision for all seniors, those with disabilities, and caregivers of the region. In general, service gaps can be attributable to funding limitations, lack of available transportation, lack of

resources, services and programs that met the needs of diverse families and older adults, and the need for increased education with outreach to access needed services.

As the demographic data indicated, the growth in the senior population will reach unprecedented proportions between now and the year 2030. The rising numbers of elderly coupled with the skyrocketing costs of healthcare in the U.S. significantly impacts the number of seniors on waiting lists for publicly-funded home and community based services. Coastal AAA has responded to this anticipated population growth and increased client need by pursuing grant dollars and forging new partnerships that help leverage limited local and state dollars and community resources to serve more clients and offer effective programs. As of January 2011, 1,209 older adults and family caregivers are waiting for services in the Coastal region, an 11.5% decrease in the 1,366 waiting in January 2010. While the AAA's efforts are positively impacting the waiting list, more than a thousand individuals wait for services, with more than 550 waiting for nutrition services. The numbers waiting for the CCSP Medicaid Waiver Program increased in by 20% in January 2011 (176) compared to numbers in January 2010 (146). Another factor impacting the growth of the non-Medicaid waiting list for services is the implementation of Georgia's Estate Recovery legislation.

In the Demographic Trends Analysis conducted by Kerr & Downs (2010), nearly half of the Coastal residents (45%) indicated that it was difficult to find others to perform essential errands to secure food, medical assistance, etc. Transportation to medical appointments, church, pharmacy, grocery store, and other shopping areas remains an unmet need for most seniors and those with disabilities in this largely rural region. The vast majority of seniors and other consumers rely on family and friends to get them where they need to go. For many, there are few or no alternatives, and isolation can become problematic. At each public hearing and group gathering held this year, transportation was consistently the number one service requested by seniors. Unfortunately, DHR Coordinated Transportation is limited to DHR consumers attending senior centers, with minimal dollars available to transport patients to dialysis or other medical appointments. While, DHR Coordinated Transportation through Coastal Regional Coaches has added a much needed option for transportation throughout most of the region, the program has limitations and restrictions that lessen its impact on the need for transportation services older adults.

In the Demographic Trends Analysis conducted by Kerr & Downs (2010), significant healthcare needs among seniors in the region were identified. Nearly half of older adults (47%) in the Coastal Georgia region suffered from diabetes, hypertension, cancer, arthritis or some other on-going condition. Further, many of these older adults have difficulty accessing what they need to maintain their physical and mental health. Lack of money is noted as the key obstacle that keeps people in the Coastal Georgia region from accessing what they need to maintain their health. More than 1 out of ten (11%) of Coastal seniors maintained they could not afford health insurance or medical prescriptions. This data suggest that significant numbers of Coastal seniors are at risk for increased chronic conditions and symptoms of mental illness due to gaps in healthcare.

Special Needs

Coastal Area Agency on Aging is increasingly working with more family members who are caring for loved ones with

Special Needs. Many are under the age of 60 and above who are the most vulnerable in the community. Outreach is done through professional organizations, health fairs, education seminars, mail outs, senior centers and the communities at large, in an effort to reach those in need of assistance to help them remain in their homes.

The ADRC Gateway provides Information and Assistance, Referrals and Resources to persons who request information about availability of services. Every effort is made to reach those living in rural areas to educate them about opportunities which might be available to them.

Coastal Area Agency on Aging works closely with organizations that target minorities, individuals with low income and Limited English Proficiency, as well as persons at risk for institutional placement. Partnerships with local county health departments, clinics, hospitals, Departments of Family and Children Services, Adult Protective Services, Georgia Legal Services, Su Casa and other community social service agencies help us reach the most vulnerable citizens in the Coastal region.

The information systems used by our agency to house client data captures income levels, impairments, unmet needs, limited English proficiency, race and ethnicity. All this data is available to the Gateway staff when making referrals for service. This allows us to identify, prioritize and serve those with the greatest needs. The Gateway staff has been trained to assist LEP/SI persons both face to face and by telephone. Program information is printed in both Spanish and English.

SERVICE DELIVERY PLAN

Service Delivery System

Community Care Services Program (CCSP)

The CCSP provides Medicaid-funded, community-based services to eligible functionally impaired individuals as an alternative to institutional placement, and is based on the premise that it is desirable to enable functionally impaired persons to reside at home or with their relatives or caregivers.

The goal of the CCSP includes supporting the following for people with functional impairments:

1. A continued ability to live in the community while receiving services
2. A continued choice in living arrangements and kinds of services received

This goal is achieved through the development of a system of community health and social services which provide a continuum of care for functionally impaired clients and assures that the least restrictive living arrangement is used to maintain independence and safety in the community.

The CCSP also includes supports and case management for family care givers using Tailored Care (TCARE). The addition of TCARE to CCSP allows the provider to focus on caregiver well-being and reduce stress and burden associated with the caregiving role for caregivers that express the need for additional supports not traditionally available through CCSP.

Coastal AAA contracts with a regional service agency accustom to delivering services in multiple counties, to provide care coordination in the Coastal region. The provider's responsibilities include brokering services, development of comprehensive service plans, monitoring service delivery to CCSP clients, monitoring service providers, client assessment, reassessment and discharge planning.

Elderly Legal Assistance Program (ELAP)

The ELAP provides persons age 60+ with legal representation, information and education in civil legal matters throughout the Coastal region. Program services include providing legal information and assistance, legal counseling, case representation and legal education session. The program focuses on helping older adults avoid more costly and time-consuming legal problems and combat exploitation. Priority is given to those with the greatest social and/or economic need, limited English speaking persons and rural or low income minorities.

Coastal AAA contracts with Georgia Legal Services to provide services for ELAP. The provider has delivered legal services to older adults in the Coastal region for many years and is the current ELAP service provider for Coastal AAA. ELAP service delivery for FY2012 will include providing legal community education for at least 2,000 individuals and providing at least 2900 hours of legal and related counseling. Service Activities will also include legal community education sessions at diverse venues throughout the Coastal region, targeting priority groups, older adults with the greatest social and/or economic need, limited English proficiency and low incomes. A minimum of 375 clients will receive case representation through ELAP in FY2012.

Georgia Legal Services will partner with the Coastal AAA to conduct outreach for ELAP and to target priority groups for service delivery. Further, this provider will assist with the development and implementation of an Elder Rights Plan for the Coastal region.

GeorgiaCares

Coastal's GeorgiaCares Program is a Volunteer-based Program that provides free, information and assistance to Medicare and Medicaid beneficiaries and their caregivers about Medicare, Medicaid and related health insurance issues including Long-Term Care insurance, prescription drug assistance programs and Medicare fraud, error and abuse.

Coastal AAA provides services through the GeorgiaCares Program in all nine counties of the Coastal region including benefits counseling, information and referral, outreach and community education. The Coastal AAA employs 1.5 full-time staff for coordination of the program, as well as one older worker and a team of volunteers. Oversight for the program is provided by the Gateway/ADRC Program Manager, AAA Director and DAS GeorgiaCares Coordinator.

Home and Community Based Services (HCBS) In-Home Services

Homemaker Services Program provides assistance to individuals unable to perform one or more of the following Instrumental Activities of Daily Living (IADLs): meal preparation, shopping for personal items/groceries, managing money/bill paying, using the telephone, light housework. Personal Care Assistance Program provides assistance to persons having difficulty with one or more of the following Activities of Daily Living (ADLs): eating, dressing, grooming, bathing, toileting, transferring in/out of bed/chair, or walking. Respite Care Services Program offers temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Some services are provided by individuals skilled in Alzheimer's care which offers temporary support for care recipients with Alzheimer's Disease.

These services are provided in the home to persons 60 years of age or older, who are functionally impaired in their ability to perform regular activities of daily living. Services are designed to capitalize on the client's remaining strengths, lessen the burden of impairment, or to lessen the caregiver's burden. Coastal AAA relies primarily on three home health agencies to provide these services in the Coastal region: Altamaha Home Care, Coastal Home Care and Best Care. All three providers are licensed home health agencies with experience serving our target population. The providers' responsibilities include:

- Providing in-home service activities including but not limited to housekeeping and home management activities, meal preparation, escort assistance, chore/errand services, client education, assistance with personal grooming and health, and temporary substitute care.
- Conducting client assessments and reassessments.
- Conducting supervisory visits monitoring aides performance.
- Developing, implementing and revising individualized service plans.
- Maintaining adequate staffing levels perform service activities
- Collaborating with the AAA, care coordination and case management staff on service delivery

Home and Community Based Services (HCBS) Caregiver Services & T-Care

The Caregivers' Assistance Program (CAP) is a multi-faceted support system focusing on caregiver needs that provides access or linkage to resources, services, and information that help to diminish caregiver stress and burden, increases caregivers' knowledge of formal in-home and community care service options, and assists caregivers with planning for service delivery for the care recipients.

Tailored Care (TCARE) is the assessment and referral process utilized through CAP to identify caregiver needs, establish a service goal and identify the appropriate strategies and services needed to accomplish that goal. The program focuses on case management, counseling and education for the caregiver, as well providing direct services for the care receiver.

In FY2012 Coastal AAA will employee two TCARE certified case managers to provide case management for CAP, expanding the program to all nine counties in the Coastal region. The program will continue to focus on caregivers with high burden scores as evidenced by the TCARE screening process.

Home and Community Based Services (HCBS) Nutrition and Wellness programs

Congregate Meals

Congregate Meals is defined as a meal provided to a qualified individual in a congregate or group setting. The meal as served meets all of the requirements of the Older Americans Act and State/Local laws.

Services in the coastal region are funded with Social Services Block Grant (SSBG), Community Based Services (CBS), Title III-C1, Administration on Aging (AOA), Nutrition Services Incentive Program (NSIP) and United States Department of Agriculture and (USDA).

Providers of Congregate Nutrition services in the coastal region for fiscal year 2012-2015 are:

- Concerted Services, Inc.
- Senior Citizens, Inc.
- Camden County Board of Commissioners
- City of Savannah
- Bryan County Board of Commissioners
- Effingham County Senior Center
- City of Brunswick
- Long County Board of Commissioners
- City of Darien / McIntosh County Board of Commissioners

Home Delivered Meals

Home Delivered Meals is defined as a meal provided to a qualified individual in his/her place of residence. The meal is served in a program administered by SUAs and/or AAAs and meets all of the requirements of the Older Americans Act and State/Local laws.

Services in the coastal region are funded with Social Services Block Grant (SSBG), Community Based Services (CBS), Title III-C2, Administration on Aging (AOA), Nutrition Services Incentive Program (NSIP) and United States Department of Agriculture and (USDA).

Providers of HDM Nutrition services in the coastal region for fiscal year 2012-2015 are:

- Concerted Services, Inc.

- Senior Citizens, Inc.
- Bryan County Board of Commissioners
- Effingham County Senior Center
- Mom's Meals
- Long County Board of Commissioners

Nutrition Education

Nutrition Education is defined as a program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers or participants and caregivers in group or individual setting overseen by a dietician or individual of comparable expertise.

In addition to the meal service provision, each contractor is responsible for coordination and providing nutrition education sessions, conducting nutrition screening activities which includes but not limited to the Determination of Need Functional Assessment (DON-R), the Determine Your Nutritional Health Checklist (NSI) and making referrals for nutrition counseling.

The Area Agency on Aging provides quarterly Nutrition and Quality Assurance Training for center managers and food service staff to ensure a comprehensive meal service program. Coastal Area Agency on Aging offers other services which maintain health; this includes Health Promotion and Disease Prevention, Medication Management, Exercise/Physical Fitness, and Recreation activities. These are provided through contract requirements.

Home and Community Based Services (HCBS) Case Management

Case management is a service designed to provide consumers access to community resources and provide on-going coordination of services and monitoring of the client's well-being. Case management services shall include, but are not limited to, the following activities:

- Assessment for, planning and implementation of service options,
- Development of individualized service plans
- Brokering of HCBS in-home services
- On-going coordination and monitoring of services
- Client linkage to available community resources that promote health, quality of life and positive outcomes
- Education about disease processes, lifestyles choices (diet, exercise, medication compliance, etc.) and preventive measures that prolong life and promote healthy living.

Coastal's HCBS Case Management program is available in Bryan, Bulloch, Chatham and Effingham Counties and focuses on clients with an unmet need of 12 or higher as determined by DON-R assessment. In addition to the results of the DON-R assessment, the following circumstances or *key factors* will also be considered by the case manager when determining eligibility and priority for case management services.

- When there are multiple or complex problems
- When there may be a need for multiple services or when multiple services are already being provided
- When personal advocacy is needed
- When informal (caregiver) supports are missing, inadequate, overwhelmed, neglectful or abusive
- When the person is homebound

- When the person's judgment about his/her needs is questionable
- When the person cannot provide adequate self-care
- When there is a history of inappropriate hospitalizations or frequent ER visits

*Caregivers receiving respite services may be eligible for case management services for themselves and/or their care receivers.

In FY2012 Coastal AAA will continue to offer case management for low-income, high-risk individuals who lack the supports necessary to remain at home. The Program will be staffed by case managers and social workers with experience in gerontology and care coordination.

Adult Day Care & Mobile Adult Day Care

The Adult Day Care Program provides personal care for dependent elders in a supervised, protective, congregate setting for at least six (6) consecutive hours each day, Monday-Friday. Services offered typically include social and recreational activities, training, counseling, meals, medications assistance, and personal care assistance.

The Mobile Adult Day Care (MADC) Program is provided by agency staff who are capable of traveling from one location to another on a daily basis, to various sites, primarily in rural locations, so as to provide care in areas that are underserved. MADC services are typically provided in one or more locations in any given week, generally in a community setting, such as a church or public facility where accommodations for services can be met.

Coastal AAA contracts with the City of Savannah, Senior Citizens Inc., and the City of Brunswick to operate three ADC programs, two Chatham County and one in Glynn County. Coastal AAA also contracts with Senior Citizens Inc. to operate a MADC program in Liberty County offering ADC services two (2) days each week.

ADC and MADC service providers operate these programs utilizing a social model and/or medical model of service delivery and serve qualified individuals, age 60 and older who are experiencing some degree of impairment in their physical and/or cognitive functioning and to individuals under the age of 60 with a diagnoses of Alzheimer's or related dementia.

Long-term care Ombudsman (LTCO)

Long-Term Care Ombudsman (LTCO) Program seeks resolution of problems and advocates for the rights of residents of long-term care facilities with the goal of enhancing the quality of life and care of residents. The program serves residents of nursing homes, personal care homes, community living arrangements, and intermediate care homes for individuals with developmental disabilities. The LTCO Program activities include facility visits, resolving complaints, community education, and advocacy.

Certified ombudsman staff and volunteers informally investigate and work to resolve complaints made by or on behalf of residents. Ombudsmen regularly visit long-term care facilities to be accessible to residents and monitor conditions. In addition, ombudsmen provide education regarding long-term care issues, identify long-term care concerns and advocate for needed change.

Coastal AAA will contract with Ward Management to administer the LTCO Program in FY2012. LTCO services will be provided throughout the Coastal region. Ward Management is Coastal's current provider for LTCO Services

and has years of experience working with older adults and providing ombudsman services.

Community Living Program (CLP)

Coastal does not currently operate a Community Living Program. During FY12 Coastal AAA will be exploring ways to offer Consumer Directed Service options through existing programs in our service delivery system. We understand the value of consumer direction and trust that our case management programs, as well as other programs we administer, can be enhanced to include a consumer direction option.

Alzheimer's Programs

Coastal AAA has implemented the Georgia REACH program, an intervention for caregivers of individuals with Alzheimer's Disease, dementia or related disorders, as we seek to:

- Learn as much as possible about the experiences of families with Alzheimer's or related dementia in this region, and
- Link families to the resources/programs that are most appropriate to meet their needs.

The goal of the program is to reduce caregiver burden and improve or sustain caregiver physical and emotional health. This is accomplished by identifying the areas that the caregiver feels are their most challenging or where they need help. Each session is tailored to address those areas. Coaching the caregiver in problem solving skills and how to access information and resources will empower them to continue to cope with their challenges even after the program is ended.

Coastal AAA has certified six (6) staff with the Georgia REACH Interventionist Model and employed (2) case managers as Georgia REACH Interventionist. Georgia REACH will be offered as a regional program in FY2012 and will focus on caregivers with high stress and burden scores.

Chronic Disease Self-Management Program (CDSMP)

Chronic Disease Self-Management Program (CDSMP) is an evidence base program. The program is based on Albert Bandura's Theory of Self-Efficacy and helps participants develop coping skills and strategies they need to manage their symptoms through action planning, interactive learning, behavior modeling, problem solving, decision-making, and social support for change. Facilitated sessions cover 17 hours of material over a six week period. Older adults will be targeted who suffer from any chronic condition. Topics to be facilitated will include pain management, eating, exercising, use of medication, emotional management, and communication with clinicians. The CDSMP/Living Well Coastal will be initially implemented in Chatham, McIntosh, Glynn, and Liberty counties. Over the next four years, development of partnership and collaboration with local and community agencies will be targeted to sustain the CDSMP Living Well Program. The AAA CDSMP Master Trainers will train lay-leaders initially in the four counties and expand to the whole region. The lay-leaders will assist by offering workshops in the community.

ALLOCATION, BUDGET AND UNITS SECTION

Allocation Methodology

The Coastal AAA uses the intrastate funding formula to formulate a basis for allocating the funds throughout the region. A great deal of care and consideration are taken to ensure that current clients will continue to receive services as well as redistributing funds from counties that have excess funding to those that have a significant amount of people on their waiting lists. The primary goals are to ensure that funds are utilized according to federal and state guidelines, and that they disbursed in an equitable manner.

Budget Narrative

There were no significant changes in funding for SFY 2012, however there was some additional MIPPA funding that was allocated that will be utilized during SFY 2012, and the ARRA/CDSMP program will continue operation through the new fiscal year.

Indirect Cost Plans

See attachment

Describe changes to services, units and persons served

The City of Darien, in conjunction with McIntosh County will provide Congregate Meal service to the senior residents of McIntosh county. This is the only new service provider that will be added for SFY 2012, there were no terminations.

AIMS Area Plan Documents

See Attachments Section

ATTACHMENT A –
AOA GOALS AND AAA OBJECTIVES CHARTS

GOAL 1: Administration on Aging - Empower older people, their families, and other consumers to make informed decisions about, and to easily access, existing health and long-term care options.

Name of Service or Program: Gateway/ADRC

SFY 2012 Goal 1 - Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Expand ADRC awareness and collaboration/ partnerships through increased outreach activities.	• Coastal AAA will increase membership on ADRC Advisory Council by 10% during FY2012-15 planning cycle over the council member at the end of FY11. • Coastal AAA will increase the number of ADRC outreach events by 10% during FY2012, FY13, FY14 and FY15 over the number of events conducted in FY11. • Coastal AAA will host ADRC Advisory Council meetings at least 2 partner agencies during FY2012.	• Aging Specialist will query ESP to identify appropriate agencies for partnership with Coastal ADRC. • Staff will identify Critical Pathway providers, hospitals, nursing homes, and home health agencies to participate on council. • Agencies will be invited to quarterly council meetings and targeted for monthly outreach events. • AAA will collaborate with an agency to host a council meeting on the southern end of the region and MHDDAD partner will work with an agency to host a meeting in the northern end of the region. • Establish letters of	

		commitment with partner agencies defining the role each agency will play in the ADRC initiative.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Expand ADRC awareness and collaboration/ partnerships through increased outreach activities.	• Coastal AAA will increase membership on ADRC Advisory Council by 10% during FY2012-15 planning cycle over the council member at the end of FY11. • Coastal AAA will increase the number of ADRC outreach events by 10% during FY13, FY14 and FY15 over the number of events conducted in FY11. • Coastal AAA will host ADRC Advisory Council meetings at least 3 partner agencies during FY2013.	• Aging Specialist will query ESP to identify appropriate agencies for partnership with Coastal ADRC. • Agencies will be invited to quarterly council meetings and targeted for monthly outreach events. • AAA will collaborate with agencies to host a council meeting on the southern end of the region and MHDDAD partner will work with agencies to host a meeting in the northern end of the region. • Establish and renew letters of commitment with partner agencies defining the role each agency will play in the ADRC initiative.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Expand ADRC awareness and collaboration/ partnerships through increased outreach activities.	• Coastal AAA will increase membership on ADRC Advisory Council by 10% during FY2012-15 planning cycle over the council member at the end of FY11. • Coastal AAA will increase the	• Aging Specialist will query ESP to identify appropriate agencies for partnership with Coastal ADRC. • Agencies will be invited to quarterly council meetings and targeted for monthly	

	number of ADRC outreach events by 10% during FY13, FY14 and FY15 over the number of events conducted in FY11. • Coastal AAA will host ADRC Advisory Council meetings at least 3 partner agencies during FY2013.	outreach events. • AAA will collaborate with agencies to host a council meeting on the southern end of the region and MHDDAD partner will work with agencies to host a meeting in the northern end of the region. • Establish and renew letters of commitment with partner agencies defining the role each agency will play in the ADRC initiative.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Expand ADRC awareness and collaboration/ partnerships through increased outreach activities.	• Coastal AAA will increase membership on ADRC Advisory Council by 10% during FY2012-15 planning cycle over the council member at the end of FY11. • Coastal AAA will increase the number of ADRC outreach events by 10% during FY13, FY14 and FY15 over the number of events conducted in FY11. • Coastal AAA will host ADRC Advisory Council meetings at least 3 partner agencies during FY2013.	• Aging Specialist will query ESP to identify appropriate agencies for partnership with Coastal ADRC. • Agencies will be invited to quarterly council meetings and targeted for monthly outreach events. • AAA will collaborate with agencies to host a council meeting on the southern end of the region and MHDDAD partner will work with agencies to host a meeting in the northern end of the region. • Establish and renew letters of commitment with partner agencies defining the role each agency will play in the	

		ADRC initiative.	

GOAL 1: Administration on Aging - Empower older people, their families, and other consumers to make informed decisions about, and to easily access, existing health and long-term care options.

Name of Service or Program: Gateway/T-Care Screening

SFY 2012 Goal 1 – Objective #2	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objectives
Maintain TCARE screening process for caregivers seeking services through the AAA.	Coastal will screen 100% of caregivers using TCARE screening tool prior to their referral for caregiver services.	• Gateway Manager will continue to have I&A Specialist trained to use TCARE Screening Tool. • I&A Specialists will use scores generated through the TCARE screening process to rank caregivers on the waiting list for services. • Gateway Manager, as a TCARE Master Trainer, will stay current on any changes to the TCARE screening tool and training I&A Specialist as needed.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Maintain TCARE screening process for caregivers seeking services through the AAA.	Coastal will screen 100% of caregivers using TCARE screening tool prior to their referral for caregiver services.	• Gateway Manager will continue to have I&A Specialist trained to use TCARE Screening Tool. • I&A Specialists will use scores generated through the TCARE screening process to rank caregivers on the waiting list for services. • Gateway Manager, as a	

		TCARE Master Trainer, will stay current on any changes to the TCARE screening tool and training I&A Specialist as needed.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Maintain TCARE screening process for caregivers seeking services through the AAA.	Coastal will screen 100% of caregivers using TCARE screening tool prior to their referral for caregiver services.	• Gateway Manager will continue to have I&A Specialist trained to use TCARE Screening Tool. • I&A Specialists will use scores generated through the TCARE screening process to rank caregivers on the waiting list for services. • Gateway Manager, as a TCARE Master Trainer, will stay current on any changes to the TCARE screening tool and training I&A Specialist as needed.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Maintain TCARE screening process for caregivers seeking services through the AAA.	Coastal will screen 100% of caregivers using TCARE screening tool prior to their referral for caregiver services.	• Gateway Manager will continue to have I&A Specialist trained to use TCARE Screening Tool. • I&A Specialists will use scores generated through the TCARE screening process to rank caregivers on the waiting list for services. • Gateway Manager, as a TCARE Master Trainer, will stay current on any changes to the TCARE screening tool	

		and training I&A Specialist as needed.	

GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.

Name of Service or Program: Community Care Services Program

SFY 2012 Goal 2 – Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objectives
Increase supports for caregivers providing primary care for CCSP clients.	• Expand TCARE services to nine county area and to non-HCBS programs in FY12. • Increase number of caregivers of CCSP clients receiving TCARE by 10% in FY12 over the numbers served in FY11.	• Train additional CCSP care coordinators in TCARE. • Market TCARE and Powerful Tools for Caregivers to caregivers of CCSP clients. • Evaluate outcomes associated with offering additional support services to determine effectiveness in reducing caregiver stress and burden and keeping CCSP clients at home.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Increase supports for caregivers providing primary care for CCSP clients.	• Increase number of caregivers of CCSP clients receiving TCARE by 5% in FY13 over the numbers served in FY12. • Expand CDSMP to caregivers of CCSP clients. Collect base line data in FY13.	• Market Evidence based wellness programs, such as CDSMP, to caregivers of CCSP clients. • Train additional staff in TCARE, CDSMP, and other support programs. • Evaluate outcomes associated with offering additional support services to determine effectiveness in reducing caregiver stress and burden	

		and keeping CCSP clients at home. • Explore additional wellness interventions/ support programs to implement in FY14.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Increase supports for caregivers providing primary care for CCSP clients.	• Offer TCARE services to caregivers through-out the nine-county region. • Increase the number of caregivers of CCSP clients collecting CDSMP by 10% in FY14 over those served in FY13. • Introduce/offer at least 2 evidence based wellness programs to clients in FY14.	• Market Evidence based wellness programs, such as CDSMP, to caregivers of CCSP clients. • Train additional staff in TCARE, CDSMP, and other support programs. • Evaluate outcomes associated with offering additional support services to determine effectiveness in reducing caregiver stress and burden and keeping CCSP clients at home. • Implement additional evidence-based wellness programs.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Maintain supports for caregivers providing primary care to care receivers enrolled in CCSP.	• Offer TCARE services to caregivers throughout the nine-county region. • Offer CDSMP throughout the nine-county region. • Provide at least 2 evidence based wellness programs to clients in FY15.	• Market Evidence based wellness programs, such as CDSMP, to caregivers of CCSP clients. • Evaluate outcomes associated with offering additional support services to determine effectiveness in reducing caregiver stress and burden and keeping CCSP clients at	

		home.	

GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.

Name of Service or Program: HCBS In-Home Category

SFY 2012 Goal 2 – Objective #2	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objectives
Increase funding for In-Home Services in the Coastal Region.	• Increase funding for in-home services by 10% by FY13 and by 15% in FY15 over funding allocated for in-home services in FY11.Identify at least 3 additional funding sources for In-home services in FY12 over sources utilized in FY11.	• Research grants opportunities and additional funding sources for in-home services. • Explore grant opportunities for CARE-Nets to leverage funding for in-home services. • Continue work on branding and marketing for agency to attract sponsors and private pay clients. • AAA management staff will meet with county and city officials to leverage additional local dollars to support in-home services.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
	• Increase funding for in-home services by 10% by FY13 and by 15% in FY15 over funding allocated for in-home services in FY11. • Identify at least 2 additional funding sources for In-home services in FY13 over sources identified in FY12.	• Research grants opportunities and additional funding sources for in-home services. • Explore grant opportunities for CARE-Nets to leverage funding for in-home services. • Continue work on branding and marketing for agency to attract sponsors and private	

		pay clients. • Provide training and workshops on grant writing for contract providers.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Increase funding for In-Home Services in the Coastal Region.	• Increase funding for in-home services by 10% by FY13 and by 15% in FY15 over funding allocated for in-home services in FY11. • Identify at least 2 additional funding sources for In-home services in FY14 over sources utilized in FY13.	• Research grants opportunities and additional funding sources for in-home services. • Explore grant opportunities for CARE-Nets to leverage funding for in-home services. • Continue work on branding and marketing for agency to attract sponsors and private pay clients.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Increase funding for In-Home Services in the Coastal Region.	• Increase funding for in-home services by 10% by FY13 and by 15% in FY15 over funding allocated for in-home services in FY11. • Identify at least 2 additional funding sources for In-home services in FY15 over sources identified in FY14.	• Research grants opportunities and additional funding sources for in-home services. • Explore grant opportunities for CARE-Nets to leverage funding for in-home services. • Continue work on branding and marketing for agency to attract sponsors and private pay clients.	

GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.

Name of Service or Program: HCBS Transportation

SFY 2012 Goal 2 - Objective #3	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Through a screening and referral process the AAA will link at risk individuals with Alzheimer's Disease and related disorders to Alzheimer's Association for safety driving assessments.	• The AAA will refer a minimum of 10 clients to Alz. Association or other service agency for a safety driving assessment in FY12, increasing referrals by 10% in FY13, 25% in FY14 and by 50% FY15, over the baseline established in FY12. * An increase in referrals is anticipated due to a marketing campaign launched in FY11 targeting caregivers of persons with dementia or related disorders.	• Gateway I&A Specialist will screen older adults in the coastal region and identify potentially at risk clients with Alz. Disease and related disorders. • Aging staff will provide clients and family caregivers information on service options – options counseling. • Refers will be made to the Alz. Association by the I&A Specialist as appropriate. • The AAA will work with the Alz. Association and other service agencies to track the outcome of these referrals.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Through a screening and referral process the AAA will link at risk individuals with Alzheimer's Disease and related disorders to Alzheimer's Association for safety driving assessments.	• The AAA will refer a minimum of 10 clients to Alz. Association or other service agency for a safety driving assessment in FY12, increasing referrals by 10% in FY13, 25% in FY14 and by 50% FY15, over the baseline established in FY12.	• Gateway I&A Specialist will screen older adults in the coastal region and identify potentially at risk clients with Alz. Disease and related disorders. • Aging staff will provide clients and family caregivers	

		information on service options – options counseling. • Refers will be made to the Alz. Association by the I&A Specialist as appropriate. • The AAA will work with the ALz. Association and other service agencies to track the outcome of these referrals.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Through a screening and referral process the AAA will link at risk individuals with Alzheimer's Disease and related disorders to Alzheimer's Association for safety driving assessments.	• The AAA will refer a minimum of 10 clients to Alz. Association or other service agency for a safety driving assessment in FY12, increasing referrals by 10% in FY13, 25% in FY14 and by 50% FY15, over the baseline established in FY12.	• Gateway I&A Specialist will screen older adults in the coastal region and identify potentially at risk clients with Alz. Disease and related disorders. • Aging staff will provide clients and family caregivers information on service options – options counseling. • Refers will be made to the Alz. Association by the I&A Specialist as appropriate. • The AAA will work with the ALz. Association and other service agencies to track the outcome of these referrals.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Through a screening and referral process the AAA will link at risk individuals with Alzheimer's Disease and related disorders to Alzheimer's Association for safety driving assessments.	• The AAA will refer a minimum of 10 clients to Alz. Association or other service agency for a safety driving assessment in FY12, increasing referrals by 10% in FY13, 25% in FY14 and by 50% FY15, over the baseline	• Gateway I&A Specialist will screen older adults in the coastal region and identify potentially at risk clients with Alz. Disease and related disorders. • Aging staff will provide clients	

	established in FY12.	and family caregivers information on service options – options counseling. • Refers will be made to the Alz. Association by the I&A Specialist as appropriate. • The AAA will work with the Alz. Association and other service agencies to track the outcome of these referrals.	

GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.

Name of Service or Program: Caregiver/ T-Care Case Management – Caregiver Assistance Program (CAP)

SFY 2012 Goal 2 – Objective #4	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objectives
Expand the use of TCARE protocol with family caregivers in the Coastal region to decrease stress and burden associated with caregiving role.	• Increase numbers served in FY12 by 10% over numbers served in FY11. • Offer TCARE in nine-counties in FY12-15 vs. five counties served during FY11. • Increase the number of TCARE care managers in Coastal region by 50% by FY15 over baseline in FY11. • 70% of caregivers complying with TCARE protocol will experience decrease in caregiver stress in FY12.	• Hire additional in-house case managers to expand program to nine-counties. • Schedule TCARE Training courses by 2nd quarter FY12. • Identify additional caregivers from waitlist to enroll in CAP. • Assess clients enrolled in CAP program each 6 months to determine effectiveness of program. • Develop marketing plan for caregiver services.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013

Expand the use of TCARE protocol with family caregivers in the Coastal region to decrease stress and burden associated with caregiving role.	• Offer TCARE in nine-counties in FY12-15 vs. five counties served during FY11. • Increase the number of TCARE care managers in Coastal region by 50% by FY15 over baseline in FY11. • 80% of caregivers complying with TCARE protocol will experience decrease in caregiver stress in FY13.	• Identify additional caregivers from waitlist to enroll in CAP. • Assess clients enrolled in CAP program each 6 months to determine effectiveness of program. • Train additional Master Trainers for TCARE.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Expand the use of TCARE protocol with family caregivers in the Coastal region to decrease stress and burden associated with caregiving role.	• Increase numbers served in FY12 by 10% over numbers served in FY11. • Offer TCARE in nine-counties in FY12-15 vs. five counties served during FY11. • Increase the number of TCARE care managers in Coastal region by 50% by FY15 over baseline in FY11. • 80% of caregivers complying with TCARE protocol will experience decrease in caregiver stress in FY14.	• Identify additional caregivers from waitlist to enroll in CAP. • Assess clients enrolled in CAP program each 6 months to determine effectiveness of program.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Expand the use of TCARE protocol with family caregivers in the Coastal region to decrease stress and burden associated with caregiving role.	• Increase numbers served in FY12 by 10% over numbers served in FY11. • Offer TCARE in nine-counties in FY12-15 vs. five counties served during FY11. • Increase the number of TCARE care managers in Coastal	• Identify additional caregivers from waitlist to enroll in CAP. • Assess clients enrolled in CAP program each 6 months to determine effectiveness of program.	

	region by 50% by FY15 over baseline in FY11. • 85% of caregivers complying with TCARE protocol will experience decrease in caregiver stress in FY15.		

GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.

Name of Service or Program: HCBS Case Management

SFY 2012 Goal 2 – Objective #5	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Provide case management to older adults in the Glynn County area following hospitalization and Emergency Room visits to promote a seamless transition home.	• In FY13, 70% of AfterCare clients will report improved management of their health conditions as a result of education and resources provided through the AfterCare program to increase to 80% by FY14 and to 90% by FY15.	• AAA will develop/update marketing/outreach materials for the AfterCare Program. • In-home Care Manager will work with hospital discharge planners in Glynn County to develop a referral process to link recent discharges to the Aftercare Program. • Care Coordination Supervisor will identify or develop an assessment process to measure the client's confidence with managing their health condition. • In-Home Care Manger will administer said assessment at intake to and discharge from the AfterCare Program. • QA Specialist will evaluate program annually to monitor progress towards program outcomes. Program evaluation will include a review of the referral process	

		to ensure that AfterCare program guidelines and the hospital standards for discharge are adhered to.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Provide case management to older adults in the Glynn County area following hospitalization and Emergency Room visits to promote a seamless transition home.	• In FY13, 70% of AfterCare clients will report improved management of their health conditions as a result of education and resources provided through the AfterCare program to increase to 80% by FY14 and to 90% by FY15.	• In-home Care Manager will work with hospital discharge planners in Glynn County to maintain a referral process to link recent discharges to the Aftercare Program. • In-Home Care Manger will administer brief assessment at intake to and discharge from the AfterCare Program. • QA Specialist will evaluate program annually to monitor progress towards program outcomes. Program evaluation will include a review of the referral process to ensure that AfterCare program guidelines and the hospital standards for discharge are adhered to.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Provide case management to older adults in the Glynn County area following hospitalization and Emergency Room visits to promote a seamless transition home.	• In FY13, 70% of AfterCare clients will report improved management of their health conditions as a result of education and resources provided through the AfterCare program to increase to 80% by FY14 and to 90% by FY15.	• In-home Care Manager will work with hospital discharge planners in Glynn County to maintain a referral process to link recent discharges to the Aftercare Program. • In-Home Care Manger will administer brief assessment at intake to and discharge	

		from the AfterCare Program. • QA Specialist will evaluate program annually to monitor progress towards program outcomes. Program evaluation will include a review of the referral process to ensure that AfterCare program guidelines and the hospital standards for discharge are adhered to.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Provide case management to older adults in the Glynn County area following hospitalization and Emergency Room visits to promote a seamless transition home.	• In FY13, 70% of AfterCare clients will report improved management of their health conditions as a result of education and resources provided through the AfterCare program to increase to 80% by FY14 and to 90% by FY15.	• In-home Care Manager will work with hospital discharge planners in Glynn County to maintain a referral process to link recent discharges to the Aftercare Program. • In-Home Care Manager will administer brief assessment at intake to and discharge from the AfterCare Program. • QA Specialist will evaluate program annually to monitor progress towards program outcomes. Program evaluation will include a review of the referral process to ensure that AfterCare program guidelines and the hospital standards for discharge are adhered to.	

GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.

Name of Service or Program: Adult Day Care (ADC)/ Mobile Adult Day Care Services

SFY 2012 Goal 2 – Objective #6	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
• Expand adult day care services to additional counties in the Coastal Region. • Increase the number of clients provided ADC services.	• Increase the number of counties with AAA funded adult day care programs in the Coastal region from 3 to 5 by FY15. • Increase the number of clients served through ADC by 10% in FY13 over baseline in FY11, and by 20% in FY15 over baseline in FY11.	• AAA Director will pursue additional funding sources for HCBS services. • AAA Director will explore establishing foundation through CARE-NETs to leverage funds for caregiver services. • AAA will seek potential ADC providers in Camden, Bryan, Bulloch, Long, McIntosh and Effingham counties. • AAA lead staff will meet with city and county officials in Camden, Bryan, Bulloch, Long, McIntosh and Effingham counties to plan for the expansion and enhancement of aging services in their county.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
• Expand adult day care services to additional counties in the Coastal Region. • Increase the number of clients provided ADC	• Increase the number of counties with AAA funded adult day care programs in the Coastal region from 3 to 5 by FY15. • Increase the number of clients	• AAA Director will pursue additional funding sources for HCBS services. • By 1st quarter FY12, AAA will identify a service provider in Camden, Bryan, Bulloch,	

services.	served through ADC by 10% in FY13 over baseline in FY11, and by 20% in FY15 over baseline in FY11.	Long, McIntosh or Effingham county to establish an ADC Program. • AAA will work with said provider to development a service plan and budget for the ADC program.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
• Expand adult day care services to additional counties in the Coastal Region. • Increase the number of clients provided ADC services.	• Increase the number of counties with AAA funded adult day care programs in the Coastal region from 3 to 5 by FY15. • Increase the number of clients served through ADC by 10% in FY13 over baseline in FY11, and by 20% in FY15 over baseline in FY11.	• AAA Director will pursue additional funding sources for HCBS services. • AAA will seek potential ADC providers in Camden, Bryan, Bulloch, Long, McIntosh and Effingham counties. • AAA lead staff will meet with city and county officials in Camden, Bryan, Bulloch, Long, McIntosh and Effingham counties to plan for the expansion and enhancement of aging services in their county. • During 4th quarter FY14, AAA will identify a service provider in Camden, Bryan, Bulloch, and Long, McIntosh or Effingham county to establish an ADC Program. • AAA will work with said provider to development a service plan and budget for the ADC program. • QA Specialist will evaluate effectiveness of new ADC	

		program.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
• Expand adult day care services to additional counties in the Coastal Region. • Increase the number of clients provided ADC services.	• Increase the number of counties with AAA funded adult day care programs in the Coastal region from 3 to 5 by FY15. • Increase the number of clients served through ADC by 10% in FY13 over baseline in FY11, and by 20% in FY15 over baseline in FY11.	• AAA Director will continue to pursue funding and resources to sustain new ADC programs. • AAA staff will provided continued technical assistance to providers. • QA Specialist will evaluate effectiveness of new ADC programs.	

GOAL 3: Administration on Aging Goal - Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.

Name of Service or Program: Nutrition Program – Congregate Meals

SFY 2012 Goal 3 – Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Increase variety and diversity in menu items provided through congregate meal programs promoting client choice and healthy eating habits.	• Target one onsite kitchen to pilot a "client choice" menu offering a hot meal and 1-2 alternate meal choices daily.	• Survey current clients to determine options meal selections • Develop two alternative of menu selections that meet 1/3 DRI/ RDA • 4th quarter the Nutrition Specialist will evaluate the program to determine client satisfaction and progress towards program outcomes.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Increase variety and diversity in menu items provided through	• Continue diversified menu at initial pilot site with a "client	• Survey current clients to determine options meal	

congregate meal programs promoting client choice and healthy eating habits.	choice" menu offering a hot meal and 1-2 alternate meal choices daily.	selections • Continue using the two alternative menus selections that meet 1/3 DRI/ RDA • By 2nd quarter, the Nutrition Specialist will share an overview of the project to other congregate site managers. • AAA will identify another site to implement pilot project during FY14.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Increase variety and diversity in menu items provided through congregate meal programs promoting client choice and healthy eating habits.	• Continue diversified menu at initial pilot site with a "client choice" menu offering a hot meal and 1-2 alternate meal choices daily. • In FY14 add a second pilot site.	• Survey current clients to determine options meal selections • Continue using the two alternative menus selections that meet 1/3 DRI/ RDA • 4th quarter the Nutrition Specialist will evaluate the program to determine client satisfaction and progress towards program outcomes.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Increase variety and diversity in menu items provided through congregate meal programs promoting client choice and healthy eating habits.	• Continue diversified menu at two pilot sites with a "client choice" menu offering a hot meal and 1-2 alternate meal choices daily.	• Survey current clients to determine options meal selections • Continue using the two alternative menus selections that meet 1/3 DRI/ RDA • By 2nd quarter, the Nutrition Specialist will share an overview of the project to other congregate site	

		managers.	

GOAL 3: Administration on Aging Goal - Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare

Name of Service or Program: Wellness Program – Matter of Balance

SFY 2012 Goal 3 – Objective #2	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Increase knowledge of health and wellness concepts amongst older adults participating in wellness programs.	• 80% of Matter of Balance (MOB) class participants will report increased knowledge of health and wellness concepts related to fall prevention, as evidenced by pre and post surveys. • Implement Matter of Balance Program in 3 Coastal Counties by 2015, Glynn, Camden and McIntosh.	• Pre and post surveys will be administered by MOB Master trainers by Sept 2011. • Coaches will be trained to administer pre and post- tests by Jan of 2012 • Post tests administered by June of 2012	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Increase knowledge of health and wellness concepts amongst older adults participating in wellness programs.	• 80% of Matter of Balance (MOB) class participants will report increased knowledge of health and wellness concepts related to fall prevention, as evidenced by pre and post surveys. • Implement Matter of Balance Program in 3 Coastal Counties by 2015, Glynn, Camden and McIntosh. • Implement MOB in 2nd county.	• Program coordinators will compile and report data for 2012 annual wellness report • Pre testing Jan 2013 • Post testing June 2013 • Program Manager will work with community partners to provide health and wellness education opportunities that meet the needs of the clients. • Implement MOB in 2nd county.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014

Increase knowledge of health and wellness concepts amongst older adults participating in wellness programs.	• 80% of Matter of Balance (MOB) class participants will report increased knowledge of health and wellness concepts related to fall prevention, as evidenced by pre and post surveys. • Implement Matter of Balance Program in 3 Coastal Counties by 2015, Glynn, Camden and McIntosh. • Implement MOB in 3rd county.	• Program Manager will compile and report data for 2013 annual wellness report • Pre testing Jan 2014 • Post testing June 2014 • Program Manager will work with community partners to provide health and wellness education opportunities that meet the needs of the clients. • Plan and facilitate training for MOB lay-leaders. • Implement MOB in 3rd county.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Increase knowledge of health and wellness concepts amongst older adults participating in wellness programs.	• 80% of Matter of Balance (MOB) class participants will report increased knowledge of health and wellness concepts related to fall prevention, as evidenced by pre and post surveys. • Implement Matter of Balance Program in 3 Coastal Counties by 2015, Glynn, Camden and McIntosh.	• Program coordinators will compile and report data for 2014 annual wellness report • Pre testing Jan 2015 • Post testing June 2015 • Program Manager will work with community partners to provide health and wellness education opportunities that meet the needs of the clients.	

GOAL 3: Administration on Aging Goal - Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare

Name of Service or Program: Chronic Disease Self-Management Program (CDSMP)

SFY 2012 Goal 3 – Objective #3	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Provide evidence-based health and wellness	• Offer 7 CDSMP workshops	• Complete surveys by	

programs to older adults in the Coastal region.	and increase knowledge of health and wellness concepts amongst at least 84 workshop participants.	participants in the CDSMP workshops by Sept 2011. • Train 24 lay leaders by Jan of 2012 • Obtain letters of commitment from LL's to maintain certification. • Compile data and report in AIMS, NCOA database, monthly CDSMP report, and quarterly narrative.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Provide evidence-based health and wellness programs to older adults in the Coastal region.	• Offer 14 CDSMP workshops and increase knowledge of health and wellness concepts amongst at least 168 workshop participants.	• Program coordinator will compile and report data for 2012 annual wellness report • Program Manager will work with community partners to provide health and wellness education opportunities that meet the needs of the clients.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Provide evidence-based health and wellness programs to older adults in the Coastal region.	• Offer 28 CDSMP workshops and increase knowledge of health and wellness concepts amongst at least 420 workshop participants.	• Coordinate with community partners to provide health and wellness education opportunities that meet the needs of the clients. • Train 48 lay leaders by Jan of 2014 • Obtain letters of commitment from LL's to maintain certification. • Plan and facilitate training for CDSMP lay-leaders.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015

Provide evidence-based health and wellness programs to older adults in the Coastal region.	• Increase the number CDSMP lay-leader by 10%	• Volunteer Coordinator will continue recruitment of volunteers to serve as CDSMP lay leaders. • CDMSP Master Trainers will offer lay leaders training by 3rd quarter FY15. • Obtain letters of commitment from LL's to maintain certification. • Program coordinator will compile and report data for 2014 annual wellness report.	

GOAL 3: Administration on Aging Goal - Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare

Name of Service or Program: Nutrition - Senior Centers

SFY 2012 Goal 3 – Objective #4	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Offer more engaging and diverse activities and programming through senior centers in the Coastal region.	• In FY12, increase the number of planned actives offered through Coastal senior centers by 50% compared to FY11, as evidenced on monthly activity calendars and required in provider contract. • Decrease the % of consumers requesting more diverse programming on the annual satisfaction surveys by 10% in FY13, 20% in FY14 and by 30% in FY15 compared to baseline data collected in FY11.	• By 1st quarter FY12, provider contracts will be revised to increase the required amount of planned programming in senior centers (3 hours). • The Wellness Coordinator will plan an annual workshop for senior center managers to offer ideas on programming and enhancing senior centers. • The AAA will assist providers in identifying new funding sources and resources to enhance their programs.	

		• The QA Specialist will monitor center activities monthly and offer feedback to providers on programming. • During 2nd quarter, the QA Specialist will survey center participants to measure their level of satisfaction with center programming.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Offer more engaging and diverse activities and programming through senior centers in the Coastal region.	• In FY13, increase the number of planned actives offered through Coastal senior centers by 100% compared to FY11, as evidenced on monthly activity calendars and required in provider contract. • Decrease the % of consumers requesting more diverse programming on the annual satisfaction surveys by 10% in FY13, 20% in FY14 and by 30% in FY15 compared to baseline data collected in FY11.	• By 1st quarter FY13, provider contracts will be revised to increase the required amount of planned programming in senior centers (4 hours). • The AAA will assist providers in identifying new funding sources and resources to enhance their programs. • Lead staff at the AAA will identify additional workshops and training opportunities for providers to enhance their programming. • The QA Specialist will monitor center activities monthly and offer feedback to providers on programming. • During 2nd quarter, the QA Specialist will survey center participants to measure their level of satisfaction with center programming.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Offer more engaging and	• In FY14, increase the number of	• By 1st quarter FY14, provider	

diverse activities and programming through senior centers in the Coastal region.	planned actives offered through Coastal senior centers by 150% compared to FY11, as evidenced on monthly activity calendars and required in provider contract. • Decrease the % of consumers requesting more diverse programming on the annual satisfaction surveys by 10% in FY13, 20% in FY14 and by 30% in FY15 compared to baseline data collected in FY11.	contracts will be revised to increase the required amount of planned programming in senior centers (5 hours). • The AAA will assist providers in identifying new funding sources and resources to enhance their programs. • Lead staff at the AAA will identify additional workshops and training opportunities for providers to enhance their programming. • The QA Specialist will monitor center activities monthly and offer feedback to providers on programming. • During 2nd quarter, the QA Specialist will survey center participants to measure their level of satisfaction with center programming.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Offer more engaging and diverse activities and programming through senior centers in the Coastal region.	• In FY15, increase the number of planned actives offered through Coastal senior centers by 200% compared to FY11, as evidenced on monthly activity calendars and required in provider contract. • Decrease the % of consumers requesting more diverse programming on the annual satisfaction surveys by 10% in FY13, 20% in FY14 and by 30%	• By 1st quarter FY15, provider contracts will be revised to increase the required amount of planned programming in senior centers (6 hours). • The AAA will assist providers in identifying new funding sources and resources to enhance their programs. • Lead staff at the AAA will identify additional workshops and training opportunities for	

	in FY15 compared to baseline data collected in FY11.	providers to enhance their programming. • The QA Specialist will monitor center activities monthly and offer feedback to providers on programming. • During 2nd quarter, the QA Specialist will survey center participants to measure their level of satisfaction with center programming.	

GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation

Name of Service or Program: GeorgiaCares SHIP

SFY 2012 Goal 4 – Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Increase access to services offered through GeorgiaCares Program through development of a regional volunteer base.	• Establish an average of 4 volunteers per county in the Coastal region trained to provide services and information specific to the GeorgiaCares Program by FY15. • Volunteers will be trained to work with both SHIP programs.	• Gateway Manager will work with Volunteer Coordinator to develop a training program for GeorgiaCares Program and to recruit potential volunteers. Training curriculum will cover SHIP programs. • Continue development of marketing plan to attract volunteers. • GaCares Coordinator will schedule outreach events throughout the region to attract potential volunteers and heighten awareness	

		about GeorgiaCares Program.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Increase access to services offered through GeorgiaCares Program through development of a regional volunteer base.	• Establish an average of 4 volunteers per county in the Coastal region trained to provide services and information specific to the GeorgiaCares Program by FY15. • Volunteers will be trained to work with both SHIP programs.	• GaCares Coordinator will schedule outreach events throughout the region to attract potential volunteers and heighten awareness about GeorgiaCares Program. • Repeat training program for volunteers at least twice during the fiscal year to maintain active volunteer base. Incorporate SHIP program objectives. • Continue marketing and recruitment for volunteers. • Volunteer Coordinator and Gateway manger will develop recognize program for volunteers.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Increase access to services offered through GeorgiaCares Program through development of a regional volunteer base.	• Establish an average of 4 volunteers per county in the Coastal region trained to provide services and information specific to the GeorgiaCares Program by FY15. • Volunteers will be trained to work with both SHIP programs.	• GaCares Coordinator will schedule outreach events throughout the region to attract potential volunteers and heighten awareness about GeorgiaCares Program. • Repeat training program for volunteers at least twice during the fiscal year to maintain active volunteer base. Incorporate SHIP program objectives. • Continue marketing and recruitment for volunteers.	

		• Volunteer Coordinator and Gateway manger will offer recognize program for volunteers.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Increase access to services offered through GeorgiaCares Program through development of a regional volunteer base.	• Establish an average of 4 volunteers per county in the Coastal region trained to provide services and information specific to the GeorgiaCares Program by FY15. • Volunteers will be trained to work with both SHIP programs.	• GaCares Coordinator will schedule outreach events throughout the region to attract potential volunteers and heighten awareness about GeorgiaCares Program. • Repeat training program for volunteers at least twice during the fiscal year to maintain active volunteer base. Incorporate SHIP program objectives. • Continue marketing and recruitment for volunteers. • Volunteer Coordinator and Gateway Manger will offer recognize program for volunteers.	

GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation

Name of Service or Program: GeorgiaCares Senior Medicare Patrol (SMP)

SFY 2012 Goal 4 – Objective #2	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Increase awareness of services offered through SMP Program through community outreach.	• Develop an outreach plan for the SMP Program that includes at a minimum the following components: marketing, volunteer recruitment, volunteering training, and community education events. • In FY12 include SMP in the AAA's advertising campaign to recruit volunteers. • Coordinate 2 community education events during Open Enrollment.	• Georgia Cares Coordinator will develop an outreach plan for SMP during first quarter FY12. • Georgia Cares Coordinator will work with Volunteer Coordinator to recruit volunteers and develop a training program/ curriculum for SMP volunteers. • GeogriaCares Coordinator will schedule and coordinate 2 community education events during Open Enrollment with a focus on empower consumers to make informed decisions concerning health insurance options and increasing understanding of Medicare. • During 3rd- 4th quarter Quality Assurance Specialist and Gateway Program Manager will conduct an annual evaluation of the SMP program to determine effectiveness of outreach activities.	

SFY 2013	SFY 2013	SFY 2013	SFY 2013
Increase awareness of services offered through SMP Program through community outreach.	• In FY13 continue marketing campaign, volunteer recruitment/ training and a minimum of 2 community outreach events.	• Georgia Cares Coordinator will work with Volunteer Coordinator to continue recruitment of volunteers and maintain training program for SMP volunteers. • GeorgiaCares Coordinator will schedule and coordinate 2 community education events during Open Enrollment with a focus on empower consumers to make informed decisions concerning health insurance options and increasing understanding of Medicare. • During 3rd- 4th quarter Quality Assurance Specialist and Gateway Program Manager will conduct an annual evaluation of the SMP program to determine effectiveness of outreach activities.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Increase awareness of services offered through SMP Program through community outreach.	• In FY14 continue marketing campaign, volunteer recruitment/training and a minimum of 2 community outreach events.	• Georgia Cares Coordinator will work with Volunteer Coordinator to continue recruitment of volunteers and maintain	

		training program for SMP volunteers. • GeogriaCares Coordinator will schedule and coordinate 2 community education events during Open Enrollment with a focus on empower consumers to make informed decisions concerning health insurance options and increasing understanding of Medicare. • During 3rd- 4th quarter Quality Assurance Specialist and Gateway Program Manager will conduct an annual evaluation of the SMP program to determine effectiveness of outreach activities.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Increase awareness of services offered through SMP Program through community outreach.	• In FY15 continue marketing campaign, volunteer recruitment/training and a minimum of 2 community outreach events.	• Georgia Cares Coordinator will work with Volunteer Coordinator to continue recruitment of volunteers and maintain training program for SMP volunteers. • GeorgiaCares Coordinator will schedule and coordinate 2 community education events during Open Enrollment with a	

		focus on empower consumers to make informed decisions concerning health insurance options and increasing understanding of Medicare. • During 3rd- 4th quarter Quality Assurance Specialist and Gateway Program Manager will conduct an annual evaluation of the SMP program to determine effectiveness of outreach activities.	

GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation.

Name of Service or Program: Elderly Legal Assistance Program

SFY 2012 Goal 4 – Objective #3	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Provide services to more older adults of limited English Proficiency, who have been traditionally difficult to reach.	• Increase the number of Hispanic/Latino clients served by 10% in FY12, 20% FY13, 35% in FY 14 and by 50% in FY15 compared to numbers served in FY11.	• The provider will utilize funding secured through Goizuetta funded outreach program to increase resources for serving clients with limited English proficiency. • The provider will maintain bilingual staff or easy-access to interpreter services throughout the contract period. • Provider will disseminate marketing materials and publications in English and Spanish. • Provider will continue to draft articles on legal issues for Spanish Language publications/ newspapers. • AAA will work with provider agency to target and identify older adults with limited English proficiency in need of legal services. • AAA and service provider will explore adding a Spanish voice mail option so that resulting new clients don't	

		reach a communications roadblock after hours.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Provide services to more older adults of limited English Proficiency, who have been traditionally difficult to reach.	• Increase the number of Hispanic/Latino clients served by 10% in FY12, 20% FY13, 35% in FY 14 and by 50% in FY15 compared to numbers served in FY11.	• The provider will utilize funding secured through Goizuetta funded outreach program to increase resources for serving clients with limited English proficiency. • The provider will maintain bilingual staff or easy-access to interpreter services throughout the contract period. • Provider will disseminate marketing materials and publications in English and Spanish. • Provider will continue to draft articles on legal issues for Spanish Language publications/ newspapers. • AAA will work with provider agency to target and identify older adults with limited English proficiency in need of legal services.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Provide services to more older adults of limited English Proficiency, who have been traditionally difficult to reach.	• Increase the number of Hispanic/Latino clients served by 10% in FY12, 20% FY13, 35% in FY 14 and by 50% in FY15 compared to numbers served in FY11.	• The provider will utilize funding secured through Goizuetta funded outreach program to increase resources for serving clients with limited English proficiency. • The provider will maintain	

		bilingual staff or easy-access to interpreter services throughout the contract period. • Provider will disseminate marketing materials and publications in English and Spanish. • Provider will continue to draft articles on legal issues for Spanish Language publications/ newspapers. • AAA will work with provider agency to target and identify older adults with limited English proficiency in need of legal services.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Provide services to more older adults of limited English Proficiency, who have been traditionally difficult to reach.	• Increase the number of Hispanic/Latino clients served by 10% in FY12, 20% FY13, 35% in FY 14 and by 50% in FY15 compared to numbers served in FY11.	• The provider will utilize funding secured through Goizuetta funded outreach program to increase resources for serving clients with limited English proficiency. • The provider will maintain bilingual staff or easy-access to interpreter services throughout the contract period. • Provider will disseminate marketing materials and publications in English and Spanish. • Provider will continue to draft articles on legal issues for	

		Spanish Language publications/ newspapers. • AAA will work with provider agency to target and identify older adults with limited English proficiency in need of legal services.	

GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation.

Name of Service or Program: Long-term Care Ombudsman

SFY 2012 Goal 4 – Objective #4	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Utilize volunteers to increase interagency collaboration, advocacy, community outreach and education provided through LTCO Program.	• Baseline data for FY11 indicates that the Coastal LTCO program has 7 volunteers. • Increase the volunteer base by 50% in FY13 and by 75% in FY15 over the baseline in FY11. • Establish training process for LTCO volunteers in FY12.	• During 1st quarter Fy12, Volunteer Services Manager and QA Specialist will work with LTCO provider to identify volunteer opportunities through LTCO program and develop training process for volunteers. • AAA will include LTCO Program in marketing, outreach and recruitment activities for volunteers. • LTCO staff will provide oversight of program volunteers and ongoing training that is program-specific. • Volunteer Services Manager and LTCO staff will evaluate the effectiveness of using volunteers in LTCO Program.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Utilize volunteers to increase interagency collaboration, advocacy, community outreach and education provided	• Increase the volunteer base by 50% in FY13 and by 75% in FY15 over the baseline in FY11. • Utilize volunteers to conduct 4 community outreach and	• AAA will include LTCO Program in marketing, outreach and recruitment activities for volunteers. • LTCO staff will provide	

through LTCO Program.	education sessions in FY13.	oversight of program volunteers and ongoing training that is program-specific. • Volunteer Services Manager and LTCO staff will evaluate the effectiveness of using volunteers in LTCO Program.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Utilize volunteers to increase interagency collaboration, advocacy, community outreach and education provided through LTCO Program.	• Increase the volunteer base by 50% in FY13 and by 75% in FY15 over the baseline in FY11. • Utilize volunteers to conduct 6 community outreach and education sessions in FY14.	• AAA will include LTCO Program in marketing, outreach and recruitment activities for volunteers. • LTCO staff will provide oversight of program volunteers and ongoing training that is program-specific. • Volunteer Services Manager and LTCO staff will evaluate the effectiveness of using volunteers in LTCO Program.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Utilize volunteers to increase interagency collaboration, advocacy, community outreach and education provided through LTCO Program.	• Increase the volunteer base by 50% in FY13 and by 75% in FY15 over the baseline in FY11. • Utilize volunteers to conduct 8 community outreach and education sessions in FY13.	• AAA will include LTCO Program in marketing, outreach and recruitment activities for volunteers. • LTCO staff will provide oversight of program volunteers and ongoing training that is program-specific. • Volunteer Services Manager and LTCO staff will evaluate the effectiveness of using	

		volunteers in LTCO Program.	

GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation.

Name of Service or Program: Elder Abuse and Consumer Fraud Prevention (Elder Rights Team Goal)

SFY 2012 Goal 4 – Objective #5	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Heighten public awareness and increase knowledge amongst professionals in the aging network about elder abuse and consumer fraud.	• In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a public-awareness event with a focus on elder abuse and consumer fraud prevention. • In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a training event or workshop for service providers and aging services professionals on elder abuse and consumer fraud prevention.	• The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event. • The Special Projects Coordinator will develop or identity a training curriculum aging services professionals. • The AAA will host and facilitate the training or workshop. • The AAA will pursue resources to further elder abuse and consumer fraud prevention awareness and training activities.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Heighten public awareness and increase knowledge amongst professionals in the aging network about	• In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a public-awareness	• The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and	

elder abuse and consumer fraud.	event with a focus on elder abuse and consumer fraud prevention. • In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a training event or workshop for service providers and aging services professionals on elder abuse and consumer fraud prevention.	other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event. • The Special Projects Coordinator will develop or identity a training curriculum aging services professionals. • The AAA will host and facilitate the training or workshop. • The AAA will pursue resources to further elder abuse and consumer fraud prevention awareness and training activities.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Heighten public awareness and increase knowledge amongst professionals in the aging network about elder abuse and consumer fraud.	• In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a public-awareness event with a focus on elder abuse and consumer fraud prevention. • In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a training event or workshop for service providers and aging services professionals on elder abuse and consumer fraud prevention.	• The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event. • The Special Projects Coordinator will develop or identity a training curriculum aging services professionals. • The AAA will host and facilitate the training or	

		workshop. • The AAA will pursue resources to further elder abuse and consumer fraud prevention awareness and training activities.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Heighten public awareness and increase knowledge amongst professionals in the aging network about elder abuse and consumer fraud.	• In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a public-awareness event with a focus on elder abuse and consumer fraud prevention. • In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a training event or workshop for service providers and aging services professionals on elder abuse and consumer fraud prevention.	• The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event. • The Special Projects Coordinator will develop or identity a training curriculum aging services professionals. • The AAA will host and facilitate the training or workshop. • The AAA will pursue resources to further elder abuse and consumer fraud prevention awareness and training activities.	

GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation.

Name of Service or Program: AAA Advocacy

SFY 2012 Goal 4 – Objective #6	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Establish an Advocacy Academy (AA) to produce graduates/ affiliates to advocate for issues relevant to older adults and the aging network.	• Establish a program that will offer potential advocates the resources and skills needed to effectively advocate for senior issues.	• Special Projects Coordinator will research successful models of advocacy programs and develop a program description and implementation plan for the Advocacy Academy. • AAA Director and Special Projects Coord. will seek funding and resources to support the project. • QA Specialist and Special Projects Coord. will develop program outcomes.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Establish an Advocacy Academy (AA) to produce graduates/ affiliates to advocate for issues relevant to older adults and the aging network.	• AA curriculum will be offered at least once during FY13.	• Special Projects Coordinator will develop AA curriculum. • Volunteer Services Manager will recruit potential advocates to complete the AA curriculum. • AAA will develop and implement marketing plan for AA project. • During 4th quarter, QA Specialist will evaluate project to determine effectiveness and progress towards	

		outcomes. AA curriculum may be tweaked based on findings and participants' feedback.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Establish an Advocacy Academy (AA) to produce graduates/ affiliates to advocate for issues relevant to older adults and the aging network.	• AA curriculum will be offered a minimum of 2 times in FY14.	• Volunteer Services Manager will recruit potential advocates to complete the AA curriculum. • AAA will continue marketing for AA project. • Special Projects Coord. will identify advocacy projects for AA graduates. • During 4th quarter, QA Specialist will evaluate project to determine effectiveness and progress towards outcomes. AA curriculum may be tweaked based on findings and participants' feedback.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Establish an Advocacy Academy (AA) to produce graduates/ affiliates to advocate for issues relevant to older adults and the aging network.	• AA curriculum will be offered a minimum of 2 times in FY15.	• Volunteer Services Manager will recruit potential advocates to complete the AA curriculum. • AAA will continue marketing plan for AA project. • Special Projects Coord. will identify advocacy projects for AA graduates. • During 4th quarter, QA Specialist will evaluate project to determine effectiveness	

		and progress towards outcomes. AA curriculum may be tweaked based on findings and participants' feedback.	

GOAL 5: Engage older adults in healthy and meaningful activities that improve their quality of life.

Name of Service or Program: AAA Volunteer Coordination

SFY 2012 Goal 5 – Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Develop a regional volunteer program through the AAA that is attractive, engaging and easy to access and provides support to the aging network.	• Increase number of active volunteers by 25% in FY12 over those volunteering through the AAA in FY11. Increase the volunteer pool by an additional 10% in FY13, FY14, and FY15. • 85% of active volunteers will rate the AAA volunteer program as good or better during FY12. • Establish an active volunteer base throughout the region by FY13, defined by a minimum of 3 volunteers per county.	• Volunteer Services Manager will work with the AAA Director to develop a marketing campaign to attract volunteers. • Volunteer Services manager will conduct interviews with each volunteer recruit to identify skills and match to appropriate volunteer opportunities. • Volunteer Services Manager will meet with community agencies and service providers to determine their workforce needs and identify volunteer opportunities. If AAA volunteers are placed with these agencies, the agencies will be included in the program's evaluation process. • Volunteer Services Manager will conduct/ attend outreach events to increase visibility of AAA volunteer program. • Third quarter FY12, Volunteer Services Manager, AAA	

		Director and QA Specialist will develop an evaluation process for the volunteer program that will include feedback from active volunteers. • Volunteer Services Manager will track # of active volunteers and volunteer hours provided throughout region.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Develop a regional volunteer program through the AAA that is attractive, engaging and easy to access and provides support to the aging network.	• Increase number of active volunteers by 25% in FY12 over those volunteering through the AAA in FY11. Increase the volunteer pool by an additional 10% in FY13, FY14, and FY15. • 90% of active volunteers will rate the AAA volunteer program as good or better in FY13. • Expand the active volunteer base throughout the region by FY13, defined by a minimum of 5 volunteers per county.	• Volunteer Services manager will conduct interviews with each volunteer recruit to identify skills and match to appropriate volunteer opportunities. • Volunteer Services Manager will meet with community agencies and service providers to determine their workforce needs and identify volunteer opportunities. If AAA volunteers are placed with these agencies, the agencies will be included in the program's evaluation process. • Volunteer Services Manager will conduct/ attend outreach events to increase visibility of AAA volunteer program. • Conduct volunteer program evaluation that will include	

		feedback from active volunteers. • Volunteer Services Manager will track # of active volunteers and volunteer hours provided throughout region.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Develop a regional volunteer program through the AAA that is attractive, engaging and easy to access and provides support to the aging network.	• Increase number of active volunteers by 25% in FY12 over those volunteering through the AAA in FY11. Increase the volunteer pool by an additional 10% in FY13, FY14, and FY15. • 90% of active volunteers will rate the AAA volunteer program as good or better in FY14. • Maintain a regional volunteer base defined by 5+ active volunteers in each county.	• Volunteer Services manager will conduct interviews with each volunteer recruit to identify skills and match to appropriate volunteer opportunities. • Volunteer Services Manager will meet with community agencies and service providers to determine their workforce needs and identify volunteer opportunities. If AAA volunteers are placed with these agencies, the agencies will be included in the program's evaluation process. • Volunteer Services Manager will conduct/ attend outreach events to increase visibility of AAA volunteer program. • Conduct volunteer program evaluation that will include feedback from active volunteers. • Volunteer Services Manager will track # of active	

		volunteers and volunteer hours provided throughout region.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Develop a regional volunteer program through the AAA that is attractive, engaging and easy to access and provides support to the aging network.	• Increase number of active volunteers by 25% in FY12 over those volunteering through the AAA in FY11. Increase the volunteer pool by an additional 10% in FY13, FY14, and FY15. • 90% of active volunteers will rate the AAA volunteer program as good or better in FY15. • Maintain a regional volunteer base defined by 5+ active volunteers in each county.	• Volunteer Services manager will conduct interviews with each volunteer recruit to identify skills and match to appropriate volunteer opportunities. • Volunteer Services Manager will meet with community agencies and service providers to determine their workforce needs and identify volunteer opportunities. If AAA volunteers are placed with these agencies, the agencies will be included in the program's evaluation process. • Volunteer Services Manager will conduct/ attend outreach events to increase visibility of AAA volunteer program. • Conduct volunteer program evaluation that will include feedback from active volunteers. • Volunteer Services Manager will track # of active volunteers and volunteer hours provided throughout region.	

LOCATION OF SERVICES CHART

ATTACHMENT B-1: Home and Community Based Services Provided in Each County Chart

	Counties → / Services ↓	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh
1.	Adult Day Care				X		X	X		
2.	Adult Day Care - Mobile					X		X		
3.	Congregate Meals	X	X	X	X	X	X	X	X	X
4.	Home Delivered Meals	X	X	X	X	X	X	X	X	X
5	Homemaker Services	X	X	X	X	X	X	X	X	X
6.	Personal Care	X	X	X	X	X	X	X	X	X
7.	Respite Care Services	X	X	X	X	X	X	X	X	X
8.	Caregiver Services		X		X	X	X			X
9.	CCSP Care Coordination	X	X	X	X	X	X	X	X	X
10.	DHR Coordinated Transportation	X	X	X	X	X	X	X	X	X
11.	ADRC	X	X	X	X	X	X	X	X	X
12.	HCBS Case Management	X	X		X	X	X			X
13.	Health Promotion / Wellness	X	X	X	X	X	X	X	X	X
14.	Medication Management	X	X	X	X	X	X	X	X	X
15.	Information & Assistance	X	X	X	X	X	X	X	X	X

ATTACHMENT B-2: Access, Elder Rights and LTCO Services Provided in Each County Chart (Form)

	Counties → / Services ↓	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh
1.	GeorgiaCares SHIP	X	X	X	X	X	X	X	X	X
2.	GeorgiaCares SMP	X	X	X	X	X	X	X	X	X
3.	Elderly Legal Assistance Program	X	X	X	X	X	X	X	X	X
4.	Long-term care Ombudsman	X	X	X	X	X	X	X	X	X
5.	Elder Abuse and Consumer Fraud Prevention Program (optional)	X	X	X	X	X	X	X	X	X

ATTACHMENT B-3: Community Care Services Provided in Each County Chart (CCSP)

	Counties → / Services ↓	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh
1.	Adult Day Health	X	X		X	X		X		
2.	Alternative Living Services	X	X	X	X	X	X	X	X	X
3.	Emergency Response System	X	X	X	X	X	X	X	X	X
4.	Home Delivered Meals	X	X	X	X	X	X	X	X	X
5	Home Delivered Services	X	X	X	X	X	X	X	X	X
6.	Personal Support Services	X	X	X	X	X	X	X	X	X
7.	Personal Support Services Extended	X	X	X	X	X	X	X	X	X
8.	Respite Care – Out of Home	X	X	X	X	X	X	X	X	X
9.	Skilled Nursing Services	X	X	X	X	X	X	X	X	X

C. COMPLIANCE DOCUMENTS

ATTACHMENT C-1: REQUEST FOR ADVANCE/BOND

Not Applicable

C. COMPLIANCE DOCUMENTS:

ATTACHMENT C-2: STANDARD ASSURANCES

STANDARD ASSURANCES - OLDER AMERICANS ACT (OAA)

Public Law 89-73, 42 U.S.C.A. § 3001, et seq., as amended

I) ORGANIZATIONAL ASSURANCES

1. SEPARATE ORGANIZATIONAL UNIT

If the Area Agency on Aging has responsibilities which go beyond programs for the elderly, a separate organizational unit within the agency has been created which functions only for the purposes of serving as the Area Agency on Aging.

2. FULL TIME DIRECTOR

The Area Agency or the separate organizational unit which functions only for the purposes of serving as the Area Agency on Aging is headed by an individual qualified by education or experience, working full-time solely on Area Agency on Aging functions and Area Plan management.

II) AREA AGENCY MANAGEMENT COMPLIANCE ASSURANCES

3. EQUAL EMPLOYMENT OPPORTUNITY (5CFR Part 900, Subpart F)

The Area Agency assures fair treatment of applicants and employees in all aspects of personnel administration without regard to political affiliation, race, color, national origin, sex, religious creed, age or handicap and with proper regard for their privacy and constitutional rights as citizens. This "fair treatment" principle includes compliance with the Federal equal employment opportunity and nondiscrimination laws. These include Title VII of the Civil Rights Act of 1964, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Rehabilitation Act of 1973, the Americans with Disabilities Act, and other relevant laws.

4. EMERGENCY MANAGEMENT PLAN

The Area Agency has assigned primary responsibility for Emergency Management planning to a staff member; the Area Emergency Management Plan which was developed in accordance with the Georgia Department of Human Resources Division of Aging Services (now the Georgia Department of Human Services, and hereafter Division of Aging Services) memorandum of February 9, 1979 shall be

reviewed at least annually and is revised as necessary. The Area Agency also assures cooperation subject to client need in the use of any facility, equipment, or resources owned or operated by the Department of Human Services which may be required in the event of a declared emergency or disaster.

As in Sec. 306 (a) (16) or (17), the Area Agency shall include information detailing how the Area Agency on aging will coordinate activities, and develop long-range emergency response plans with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for relief service delivery.

5. DIRECT PROVISION OF SOCIAL SERVICES

No Title III supportive services, nutrition services, or in-home services are being directly provided by the Area Agency except where provision of such services by the Area Agency has been determined by the Division of Aging Services to be necessary in assuring an adequate supply of such services; or where services are directly related to the AAA administrative functions; or where services of comparable quality can be provided more economically by the Area Agency.

6. REVIEW BY ADVISORY COUNCIL

The Area Agency has provided the Area Agency Advisory Council the opportunity to review and comment on the Area Plan and operations conducted under the plan.

7. ATTENDANCE AT STATE TRAINING

The Area Agency assures that it will send appropriate staff to those training sessions required by the Division of Aging Services.

8. PROPOSAL FOR PROGRAM DEVELOPMENT AND COORDINATION

The Area Agency has submitted the details of its proposals to pay for program development and coordination as a cost of supportive services to the general public (including government officials, and the aging services network) for review and comment. The Area Agency has budgeted its total allotment for Area Plan Administration before budgeting Title III-B funds for Program Development in accordance with 45 CFR 1321.17(14).

9. COMPETITIVE PROCESS FOR NUTRITION PROVIDERS, SUPPORTIVE SERVICES PROVIDERS, AND FOOD VENDORS

a) Nutrition providers and supportive service providers will be selected through competitive negotiations or a Request for Proposal process. Documentation will be maintained in the Area Agency files.

b) Nutrition service providers who have a central kitchen or who prepare food on- site must obtain all food and supplies through appropriate procurement procedures, as specified by the Division of Aging Services.

c) Food vendors will be selected through a competitive sealed bid process.

d) Nutrition service providers who have a central kitchen or who prepare meals on-site must develop a food service proposal.

e) Copies of all Requests for Proposals and bid specifications will be maintained at the Area Agency for review.

10. REPORTING

The Area Agency assures that it will maintain required data on the services included in the Area Plan and report such data to the Division of Aging Services in the form and format requested.

11. NO CONFLICT OF INTEREST

No officer, employee, or other representative of the Area Agency on Aging is subject to a conflict of interest prohibited under this Act; and mechanisms are in place at the Area Agency on Aging to indentify and remove conflicts of interest prohibited under this Act.

III) SERVICE PROVISION ASSURANCES

12. MEANS TEST

No Title III service provider uses a means test to deny or limit receipt of Title III services under the Area Plan.

13. EQUAL EMPLOYMENT OPPORTUNITY BY SERVICE PROVIDERS

The Area Agency assures that service providers provide fair treatment of applicants and employees in all aspects of personnel administration without regard to political affiliation, race, color, national origin, sex, religious creed, age or handicap and with proper regard for their privacy and constitutional rights as citizens. This "fair treatment" principle includes compliance with the Federal equal employment opportunity and nondiscrimination laws. These include Title VII of the Civil Rights Act of 1964, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Rehabilitation Act of 1973, the Americans with Disabilities Act, and other relevant laws.

14. STANDARDS/GUIDELINES/POLICIES AND PROCEDURES

The Area Agency and all service providers will comply with all applicable Georgia Department of Human Services Division of Aging Services standards, guidelines, policies, and procedures.

NOTE: No additional waiver of the Multi-Purpose Senior Center (MPSC) Standards is necessary IF the Area Agency has previously obtained such a waiver AND there have been no changes since the submission of the waiver request.

15. SPECIAL MEALS

Each nutrition program funded under the Area Plan is providing special meals, where feasible and appropriate, to meet the particular dietary needs, arising from the health requirements, religious requirements, or ethnic backgrounds of eligible individuals.

16. CONTRIBUTIONS

Older persons are provided an opportunity to voluntarily contribute to part or all of the cost of Title III services received under the Area Plan, in accordance with procedures established by the Division of Aging Services. Title III services are not denied based on failure to contribute.

The area agency on aging shall ensure that each service provider will-

(A) provide each recipient with an opportunity to voluntarily contribute to the cost of the service;

(B) clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;

(C) protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution;

(D) establish appropriate procedures to safeguard and account for all contributions; and

(E) use all collected contributions to expand the service for which the contributions were given and to supplement (not supplant) funds received under this Act.

Voluntary contributions shall be allowed and may be solicited for all services for which funds are received under this Act if the method of solicitation is not coercive. Such contributions shall be encouraged for individuals whose self-declared income is at or above 185 percent of the poverty line, at contribution levels based on the actual cost of services.

17. PERSONNEL POLICIES

Written personnel policies affecting Area Agency and service provider staff have been developed to include, but are not limited to, written job descriptions for each position; evaluation of job performance; annual leave; sick leave; holiday schedules; normal working hours; and compensatory time.

18. COORDINATION WITH TITLE V NATIONAL SPONSORS

The Area Agency will meet at least annually with the representatives of Title V Older American Community Service Employment Program (formerly SCSEP) sponsors operating within their Planning and Service Areas (PSAs) to discuss equitable distribution of enrollee positions within the PSA and coordinate activities as appropriate.

19. PREFERENCE IN PROVIDING SERVICES

The Area Agency on Aging provides assurance that preference will be given to services to older individuals with the greatest economic need and older individuals with the greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the Area Plan. [Section 305 (a) (2) (E)]

IV) TITLE III, PART A ASSURANCES

The Area Agency on Aging assures that it shall --

20. Sec. 306(a)(2) - provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the Area Agency on Aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

21. Sec. 306(a) (4) (A) (i) (I) - provide assurances that the Area Agency on Aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub clause (I);

22. Sec. 306(a)(4)(A)(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

23. Sec. 306(a)(4)(A)(iii) - With respect to the fiscal year preceding the fiscal year for which such plan is prepared, the Area Agency on Aging shall—

(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a) (4) (A) (i).

24. Sec. 306(a)(4)(B)(i) - provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance;

25. Sec. 306(a)(4)(C) - provide assurance that the Area Agency on Aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

26. Sec. 306(a)(5) provide assurances that the Area Agency on Aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

27. Sec. 306(a)(6)(A) - take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

28. Sec. 306(a) (6) (B) -serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals

29. Sec. 306(a) (6) (C) (i) – enter, where possible, into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that-

> (I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or
>
> (II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 675(c)(3) of the Community Services Block Grant Act (42 U.S.C. 9904(c)(3)); and

30. Sec. 306(a) (6) (C) (iii) - make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out

Federal service programs administered by the Corporation for National and Community Service), in community service settings;

31. Sec. 306(a)(6)(D) – establish and maintain an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

32. Sec. 306(a)(6)(F) – The Area Agency on Aging will in coordination with the State Agency on Aging (Georgia Department of Human Services Division of Aging Services) and the State agency responsible for mental health services (Georgia Department of Behavioral Health and Developmental Disabilities), increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the Area Agency on Aging with the mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

33. Sec. 306(a)(7) - provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by –

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better –

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidenced-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information related to –

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources.

34. Sec. 306(a) (8) that case management services provided under this title through the area agency on aging will -

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that -

(i) gives each older individual seeking service under this subchapter a list of agencies that provide similar services within the jurisdiction of the area agency on Aging;

(ii) gives each individual describe in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirement described in clauses (i) through (iii); and

(v) is not located, does not provide, and does not have a direct or indirect ownership or controlling interest in, or a direct or indirect affiliation or relationship with, an entity that provides, services other than case management services under this title.

35. Sec. 306(a)(9) - provide assurances that the Area Agency on Aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this subchapter.

36. Sec. 306(a) (10) establish a grievance procedure for older individuals who are dissatisfied with or denied services under this subchapter;

37. Sec. 306 (a) (11) – provide information and assurances by the Area Agency on Aging concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the Area Agency on Aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the Area Agency on Aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the Area Agency on Aging will make services under the area plan available; to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

38. Sec**.** 306 (a**)**(13)(A) - provide assurances that the Area Agency on Aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

39. Sec. 306 (a) (13) (B) - provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State Agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship.

40. Sec. 306(a)(13)(C) - provide assurances that the Area Agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

41. Sec. 306(a)(13)(D) - provide assurances that the Area Agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

42. Sec. 306(a**)**(13)(E) - shall provide assurances that the Area Agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

43. Sec. 306(a**)** (14) -. provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

44. Sec. 307(a)(15)(A) - provide assurances that funds received under this title will be used - to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

45. Sec. 307(a)(15)(B) – provide assurances that funds received under this title will be used in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212 (42 U.S.C.A. § 3020c);

46. Sec. 306(a) (16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

47. Conduct annual evaluations of, and *public hearings* on, activities carried out under the area plan and an annual evaluation of the effectiveness of outreach conducted under paragraph (5) (B);

48. Furnish appropriate technical assistance and timely information in a timely manner, to providers of supportive services, nutrition services, or multipurpose senior centers in the planning and service area covered by the area plan;

49. Sec. 306 (a)(6)(C)(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

50. Develop and publish methods by which priority of services is determined, particularly with respect to the delivery of services under paragraph (2);

51. Establish effective and efficient procedures for coordination of -

(I) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

52. Identify the public and private nonprofit entities involved in the prevention, identification, and treatment of the abuse, neglect, and exploitation of older individuals, and based on such identification, determine the extent to which the need for appropriate services for such individuals is unmet;

53. Compile available information on institutions of higher education in the planning and service area regarding-

(I) the courses of study offered to older individuals by such institutions; and

(II) the policies of such institutions with respect to the enrollment of older individuals with little or no payment tuition, on a space available basis, or on another special basis;

(III) include in such compilation such related supplementary information as may be necessary; and

(IV) based on the results of such compilation, make a summary of such information available to older individuals at multipurpose senior centers, congregate nutrition sites, and other appropriate places;

54. Sec. 306 (a) (6) (Q) enter into voluntary arrangements with nonprofit entities (including public and private housing authorities and organizations) that provide housing (such as housing under section 202 of the Housing Act of 1959 (12 U.S.C. 1701Q) to older individuals, to provide-

(I) leadership and coordination in the development, provision, and expansion of adequate housing, supportive services, referrals, and living arrangements for older individuals; and

(ii) advance notification and non-financial assistance to older individuals who are subject to eviction from such housing;

55. List the telephone number of the agency in such telephone directory that is published, by the provider of local telephone service, for residents in any geographical area that lies in whole or in part in the service and planning area served by the agency -

(I) under the name "Area Agency on Aging";

(ii) in the unclassified section of the directory; and

(iii) to the extent possible, in the classified section of the directory, under a subject heading designated by the Commissioner by regulation; and

56. Identify the needs of older individuals and describe methods the area agency on aging will use to coordinate planning and delivery of transportation services (including the purchase of vehicles) to assist older individuals, including those with special needs, in the area;

57. Provide assurances that any amount received under part E will be expended in accordance with such part;

58. Provide assurances that any amount received under part F will be expended in accordance with such part;

59. Provide assurances that any amount received under part G will be expended in accordance with such part;

60. In the discretion of the area agency on aging, provide for an area volunteer services coordinator, who shall -

(A) encourage, and enlist the services of, local volunteer groups to provide assistance and services appropriate to the unique needs of older individuals within the planning and services area; and

(B) encourage, organize, and promote the use of older individuals as volunteers to local communities within the area; and

(C) promote the recognition of the contribution made by volunteers to programs administered under the area plan;

(D) assure that the activities conform with -

(i) the responsibilities of the area agency on aging, as set forth in this subsection; and

(ii) the laws, regulations, and policies of the State served by the area agency on aging;

61. Projects in the planning and service area will reasonably accommodate participants as described in the Act'

62. Before an Area Agency on Aging requests a waiver under paragraph (1) of this subsection, the Area Agency shall conduct a timely public hearing in accordance with the provisions of this paragraph. The Area Agency on Aging requesting a waiver shall notify all interested parties in the area of public hearing and furnish the interested parties with an opportunity to testify.

63. The Area Agency on Aging shall prepare a record of the public hearing conducted pursuant to Section 306(b)(2)(A) and shall furnish the record of public hearing with the request for a waiver made to the State under paragraph (1).

64. Provide that the Area Agency on Aging will facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who -- --

(A) Reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) Are patients in hospitals and are at risk of prolonged institutionalization; or
(C) Are patients of long-term care facilities, but who can return to their homes in community-based options are provided to them.

65. Provide that the Area Agency on Aging will facilitate coordination of community-based, long-term care services designed to enable older individuals to remain in their homes, by means including –

(A) development of case management services as a component of the long-term care services, consistent with the requirements of paragraph (64);

(B) involvement of long-term care providers in the coordination of such services; and

(C) increasing community awareness of and involvement in addressing the needs of residents of long-term care facilities;

66. Provide that case management services provided under this title through the area agency on aging will--

(A) not duplicate case management services provided through other Federal and State programs;
(B) be coordinated with services described in subparagraph (A); and
(C) be provided by a public agency or a nonprofit private agency that--
  (i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;
  (ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;
  (iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or
  (iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

67. Provide that the Area Agency on Aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in Section 203(b) within the planning and service area.

68. Provide that the Area Agency on Aging, with respect to the needs of older individuals with severe disabilities, will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with

disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals and disabilities.

V) TITLE VII/LONG-TERM CARE OMBUDSMAN PROGRAM ASSURANCES

69. The Area Agency assures the provision of long-term care ombudsman services that fulfill the mandate for sub state ombudsman programs as specified in Title III and Title VII of the Older Americans Act and in state law (O.C.G.A Section 31-8-50, et seq.).

70. The Area Agency provides assurance that, in carrying out programs with respect to the prevention of elder abuse, neglect, and exploitation under the Older Americans Act, it will expend from the funds appropriated under Section 702 (b) of the Older Americans Act not less than the total amount allocated by the Division of Aging services for that fund source.

71. Provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under Section 307(a)(9), will expend not less than the total amount of funds appropriated under the Older Americans Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title;

VI) TITLE VII/LEGAL ASSISTANCE ASSURANCES

72. Sec. 307(11) (A) provide assurances that the Area Agency on Aging will –

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals in pro bono and reduced fee basis

73. Sec. 307(11)(D) provide assurances that, to the extent practicable, that legal assistance furnished under the Area Plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals.

74. Sec. 307(11)(E) provide assurances that Area Agencies on Aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

My signature below indicates that the Coastal Regional Commission Area Agency on Aging is in compliance and will maintain compliance with all aforementioned Standard Assurances.

_____ _____

Jill Jackson-Ledford Date

Area Agency on Aging Director

_____ _____

Dan Coty, CRC Council Chairman Date

Coastal Regional Commission

C. COMPLIANCE DOCUMENTS:

ATTACHMENT C-3: LETTER REQUESTING WAIVER OF STANDARD ASSURANCES

C. COMPLIANCE DOCUMENTS:

ATTACHMENT C-4 - BOARD RESOLUTION

D. REQUIRED PLANS:

ATTACHMENT D-1 – ANNUAL ELDER RIGHTS PLAN

COASTAL AAA ELDER RIGHTS PLAN

Coastal AAA and its service providers and partner agencies have always been responsive to the needs of older adults and individuals with disabilities in the Coastal region. AAA staff and providers are trained to identify signs of abuse and exploitation and receive regular information and updates from the Aging Services Coordinator and Resource Specialist regarding programs, services and resources available to victims of abuse. AAA lead staff dialogue with service providers and staff about the dynamics of elder abuse on an on-going basis. Providers and staff are required to follow-up on client complaints, trained to look for changes in client behavior and encouraged to stay current on preventive techniques and practices that help to safeguard the clients we serve.

During October 2008, the AAA obtained a $10,000 grant from the Nation Center for the Prevention of Elder Abuse (NCPEA) to develop a new coalition to work on Elder Abuse issues in the community. Elder Abuse, particularly financial exploitation, is the biggest cross-cutting issue for all Elder Rights Programs. This Coalition meets monthly and has established a Strategic Plan, projects, committees and an 'extranet' site. Although the grant required that the Coalition be viable for at least one year, the AAA has continued to facilitate monthly meetings of the Coastal Alliance for the Protection of Elders (CAPE), a multi-disciplinary approach to educate the community about the growing epidemic of Elder Abuse. Activities are being planned for World Elder Abuse Awareness Day 2011. CAPE members include representatives from all Coastal Elder Rights programs and APS.

In addition, Elder Rights program staff are participating in other coalitions throughout the region including the Chatham County S.A.L.T. Council, the Chatham County Multi-disciplinary Team and the Glynn County Task Force Against Family Violence. Many of our cross-cutting issues identified by our Elder Rights Team are the focus of these Coalitions (Elder Abuse, Domestic Violence, Financial Fraud, Elder Shelters, etc).

Elder Rights team:

The Coastal Elder Right's Team is led by the AAA and co-led by our Elder Legal Assistance Program provider, Georgia Legal Services. The AAA partners with the ELAP provider in the development of the Elder Rights Plan utilizing recommendations and input from the Elder Rights Team. The Elder Rights Team meets quarterly to plan team activities and discuss progress towards the team's established goals. Third quarter meetings are reserved for discussion of issues affecting older adults and individuals with disabilities as well as issues impacting the agencies that serve this vulnerable population. During this meeting the team selects the area(s) of focus for the elder rights plan and cross-cutting issues are identified.

POTENTIAL ELDER RIGHTS TEAM MEMBERS			
√	AAA staff	√	Georgia Legal Services
	AARP Chapter Representative		Health Department
	Adult Protective Services Representative		Hospitals
	Chiropractors		Judge or Clerks
	Community/Service Groups (Lions Club, Kiwanis Club Elks Club, etc.)		Law Enforcement
	Council on Aging	√	Local Attorneys
	Domestic Violence Advocates	√	Long-term care Ombudsman
	Dentists		Mental Health Professionals
	EMS/Paramedics		Neighborhood Watch Programs
√	Elderly Legal Assistance Provider		Older Persons who is an advocate
	Financial Institutions Employees		Rape Crisis Center Representative
	Faith based leaders		Solicitor or District Attorney
√	Gateway/ADRC Representative	√	Triad/SALT Council Representative
√	GeorgiaCares		Victim Witness Assistants
	Other (describe):		Other (describe):

During 3rd quarter FY11 and leading up to World Elder Abuse Day 2011, lead staff from the AAA will be scheduling meetings with other agencies throughout the Coastal region identified as important partners for the Elder Rights Team. These meetings will be used to introduce new agencies to the issues being addressed by the Elder Rights Team as well as the team's purpose and goals. Interested agencies will be encouraged to join the Elder Rights Team and assigned activities towards accomplishing the team's FY12 goals and objectives.

We further anticipate participation on Coastal's Elder Rights Team will be positively impacted by the AAA's new approach to marketing and branding, as well as impacted by new partnerships developed in FY11 as new programs and initiatives have been implemented.

c) **Describe the process for determining the cross cutting priority issue.**

1. How and why was this issue chosen?

During planning cycle FY08-11, Coastal has used various methods to gather input from team members on the most relevant areas impacting our target population and the providers that serve them, such as group discussions, webinars, and on-line surveys. Through these processes, we have recognized that the need for increased awareness, funding, training, volunteers and resources remain the primary areas of focus. Thus the Elder Rights Team further recognizes the need to develop long-term goals that address multiple areas for

improvement with objectives, that that when accomplished, will offer lasting improvements to the service systems we operate under.

2. Describe the envisioned role of each Elder Rights Team member will play in addressing this issue.

The Elder Rights Team will develop the training curriculum that will used to train other service agencies and their personnel on topics of consumer fraud and elder abuse. Team members and the agencies they represent will partner with the AAA to host an awareness event to increase outreach and educate the community about elder abuse. Team members will work with the AAA's Volunteer Coordinator to help identify volunteers that work with the team on plan activities. Lastly, the Elder Rights Team will assist the AAA in the development of the Advocacy Academy Program to further identify volunteers and advocates to work on elder rights issues.

GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation.

Name of Service or Program: Elder Abuse and Consumer Fraud Prevention

SFY 2012 Goal 4 – Objective #4	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Heighten public awareness and increase knowledge amongst professionals in the aging network about elder abuse and consumer fraud.	• In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a public-awareness event with a focus on elder abuse and consumer fraud prevention. • In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a training event or workshop for service providers and aging services professionals on elder abuse and consumer fraud prevention.	• The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event. • The Special Projects Coordinator will develop or identity a training curriculum aging services professionals. • The AAA will host and facilitate the training or workshop. Target audience will include members of Law Enforcement. Emphasis will be placed on encouraging service providers to make mandatory reports to APS and HFR. • The AAA will pursue resources to further elder abuse and consumer fraud prevention awareness and training activities.	

SFY 2013	SFY 2013	SFY 2013	SFY 2013
Heighten public awareness and increase knowledge amongst professionals in the aging network about elder abuse and consumer fraud.	• In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a public-awareness event with a focus on elder abuse and consumer fraud prevention. • In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a training event or workshop for service providers and aging services professionals on elder abuse and consumer fraud prevention.	• The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event. • The Special Projects Coordinator will develop or identity a training curriculum aging services professionals. • The AAA will host and facilitate the training or workshop. Target audience will include members of Law Enforcement. Emphasis will be placed on encouraging service providers to make mandatory reports to APS and HFR. • The AAA will pursue resources to further elder abuse and consumer fraud prevention awareness and training activities.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Heighten public awareness and increase knowledge amongst professionals in the aging network about elder abuse and consumer	• In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a public-awareness event with a focus on elder	• The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups,	

fraud.	abuse and consumer fraud prevention. • In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a training event or workshop for service providers and aging services professionals on elder abuse and consumer fraud prevention.	such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event. • The Special Projects Coordinator will develop or identity a training curriculum aging services professionals. • The AAA will host and facilitate the training or workshop. Target audience will include members of Law Enforcement. Emphasis will be placed on encouraging service providers to make mandatory reports to APS and HFR. • The AAA will pursue resources to further elder abuse and consumer fraud prevention awareness and training activities.	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Heighten public awareness and increase knowledge amongst professionals in the aging network about elder abuse and consumer fraud.	• In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a public-awareness event with a focus on elder abuse and consumer fraud prevention. • In FY12, FY13, FY14 and FY15, the AAA will conduct or collaborate with other agencies to host a training event or	• The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event. • The Special Projects	

	workshop for service providers and aging services professionals on elder abuse and consumer fraud prevention.	Coordinator will develop or identity a training curriculum aging services professionals. • The AAA will host and facilitate the training or workshop. Target audience will include members of Law Enforcement. Emphasis will be placed on encouraging service providers to make mandatory reports to APS and HFR. • The AAA will pursue resources to further elder abuse and consumer fraud prevention awareness and training activities.	

D. REQUIRED PLANS: ATTACHMENT D-2 – LONG-TERM CARE OMBUDSMAN (LTCO) ANNUAL PLAN

Georgia Community Long-Term Care Ombudsman Program

Annual Plan State Fiscal Year 2012

Community LTCO Program : Ward Management Services, Inc.
Name of LTCO Coordinator : Pam Lipsitz
A. General Program Information

I. Long-Term Care Ombudsman staff
How many hours are in a full-time work week in your agency? 40
List LTCO staff (certified or pending certification) and the hours per week they spend working for the LTCO Program[1]:

Ombudsman Program Coordinator:	40
Ombudsman Staff position:	40
Ombudsman Staff position:	40
Program Director position:	10

List any non-certified LTCO staff (providing clerical assistance, but not directly serving residents through routine visits or complaint processing) and the hours per week they spend working for the LTCO Program:

Fiscal Data Entry Clerk:	10

II. Volunteers[2]

LTCO Volunteers (Certified)	1
Volunteer Visitors	13
Volunteers who contribute in other ways	1
TOTAL	15

(if a volunteer fits in more than one category above, include them only once in the total)

1 Indicate all hours worked to benefit the LTCO Program, including direct services to residents and LTCO program administration, such as staff supervision, volunteer management, and data entry.

2 This number should not include individuals whose sole volunteering role is serving on an advisory council or whose contribution to the LTCOP is related to their employment (e.g., guest speaker at an in-service training.)

Program Plan
Mandatory Program Components
A. Complaint Processing

Indicate Program plans to provide prompt responses to complaints and confidential access to an ombudsman, including when ombudsman staff are not immediately available (for example, when staff are in the field, attending conferences, or on leave, or when positions are vacant).

Complaint processing is our program's top priority and complaints are resolved to the satisfaction of the resident as delineated in our program standards. The Coastal LTCOP will continue to meet the standards through the following measures:

Prompt responses to complaints will be assured by initiating responses and investigations from complaints received in person, by phone, fax or email as follows:

Abuse complaints in which the resident may be at risk will be responded to on the same day or by the next working day. Abuse complaints in which there is no reason to believe the resident is at risk will be addressed within three (3) working days, but not exceeding three calendar days when possible. Transfer and discharge complaints will be responded to within five (5) working days if possible or by the last day of a bed hold or last day for filing an appeal. All other complaints will be processed within seven (7) working days.

The Ombudsman staff will handle any complaints received in a confidential manner, unless the complainant authorizes them to disclose particular information. In some cases, complaints or issues are addressed without identifying the individual who made the complaint. The Ombudsman staff will ask the complainant and the resident how they want their complaint handled. Confidential information will not be disclosed without the express permission of the complainant or the resident

Other information related to complaint processing:
The Coastal LTCOP has developed and utilizes a fact sheet that contains information about state and local resources that complainants may find helpful when pursuing resolutions to the issues or problems they are experiencing.
Referrals are made to the Healthcare Facility Regulation Unit w/n the Department of Community Health and Georgia Legal Services and other agencies when appropriate.
Coastal staff discusses cases as needed in the processing of complaints. All staff may also call the SLTCOP for guidance and assistance.

Adequate staff and telephone coverage is assured as follows: All staff can access a voice mail system in which they can retrieve messages in a timely manner. An assigned LTCO staff will cover calls and cases due to other staff absences. Voice mail and email messages will be changed when appropriate.

In addition, each staff person has access to email in order to communicate with each other as well as receive and send messages from the public and other professionals. Staff can also be located through Internet web sites such as NCCNHR, COCO and SLTCOP.

B. Information and Assistance

Indicate Program plans to provide prompt responses to requests for information and assistance and confidential access to an ombudsman, including when ombudsman staff are not immediately available (for example, when staff are in the field, attending conferences, or on leave, or when positions are vacant).

All information and assistance requests is responded to during the same day when possible and, in all cases, within two working days. The access procedures apply with I & A as described with complaint processing.

The Coastal Area Ombudsman Program will respond to phone requests for assistance within two (2) working days and a confidential voice mail system will record messages while LTCO are working in the field. Also, LTCO staff will be offered reimbursement at a basic monthly rate for cell phone service, so that they may respond to calls while in the field.

C. Routine Visits

Indicate Program plans for routine visits as follows:

28 Current number of nursing homes
28 Number that will be visited during each calendar quarter
108 Current number of personal care homes
108 Number of personal care homes that will be visited during each calendar quarter
22 Current number of community living arrangements (no requirements to visit)
0 Current number of intermediate care facilities for the mentally retarded (ICF/MR)

Routine visits will be conducted in order to create LTCO presence in facilities as frequently as possible. The minimum standards will be met when visiting nursing homes and personal care homes on a quarterly basis. Complaint processing will remain the highest priority for the Coastal Program and complaint visits will be made first and visits to problematic facilities will be a priority. Routine visits are unannounced and staggered so that facility staff can not predict the time of a visit. Visits to Community living arrangement homes will only be made during complaint investigations, and routine visits will be eliminated to CLAs, yet staff may still visit or call these homes to keep a presence in the CLA homes since we still maintain that authority. LTCO staff may also utilize "consultation to facilities" by phone in nursing homes in which a monthly visit has not been made, and the staff person feels a consultation or communication with the facility staff would be beneficial.

D. Issues Advocacy

Indicate what issue(s) the Program plans to address in SFY 2012 and what types of activities the Program plans to pursue in order to address the issue(s).

or

Indicate that the Coordinator plans to request an amendment to this Plan which shall indicate this information. Such an amendment shall be provided to the provider agency, the area agency on aging and the Office of the State Long-Term Care Ombudsman (State Office) for review and approval no later than September 1, 2012

The Coastal Area Ombudsman Program will continue to address the issue of elder abuse.

An area of advocacy that the Coastal LTCOP was involved in was the funding of a special prosecutor of elder abuse in the Chatham county District Attorney's office. Our program will continue to collaborate with the DA's office on elder abuse cases when appropriate.

In addition, we have seen an increase in our area in the financial exploitation of residents of facilities by staff. We have seen

cases of identity theft and fraud by staff gaining access to resident's personal social security numbers, credit and debit cards, checkbooks, bank statements and other mail which they receive at their ltc residence. The protection of resident information may be discussed with residents individually and at resident council meetings. Information may be sent by letter to facilities on this topic. The Coastal Program may also collaborate with other agencies on this issue.

In addition, financial exploitation of resident's funds by their families continues to be an issue. Many facilities issue discharge notices to residents when their bills are not paid. Our program staff continues to work to resolve these discharges with families, staff, Adult Protective Services and Georgia Legal Services ELAP (Elderly Legal Assistance Program). Most of these cases are addressed individually since the issue may vary from resident to resident. However, program staff may still find this issue to be widespread and choose to provide letters to facilities exemplifying the discharge process or provide information to facilities about a more appropriate protocol to be used with residents whose family members are using funds inappropriately rather than issue a discharge notice to that resident.

E. Resident Councils

Indicate Program activities planned related to resident councils.

It is projected that the Coastal Area will have involvement in 100% of the resident councils in the service area, thus, a minimum of 26 units of resident council activities will be provided. Two (2) of our nursing homes of the 28 are sub-acute/transitional care units in hospitals and do not hold resident council meetings since the residents are there for short term rehabilitation and rarely transition to long-term care. Units may be provided by attending resident council meetings, visiting with the resident council presidents, reviewing minutes of the resident council meetings or writing to councils regarding our services.

F. Volunteer Management

Indicate Program plans to recruit, train, retain, and/or manage volunteers.

There are currently 13 volunteers utilized in the Coastal GA Area as volunteer visitors. One volunteer visitor currently (1-2011) maintains certification as a certified visitor, but will become a volunteer visitor in FY 2012. We have one (1) volunteer who helps the Program Director with other activities such as financial and programmatic data input.

We have continued to accept South University pharmaceutical students as volunteers. They are primarily serving as volunteer visitors, but may pursue special projects as well. For the last several years, these volunteers provide educational sessions to residents about resident's rights mostly by playing Resident's Rights Bingo with residents in both nursing homes and assisted living facilities.

Volunteers will be recruited as the need arises. Training of volunteers is carried out in accordance with the Volunteer Training Manual for the Long Term Care Ombudsman Program. Volunteers must be certified in order to handle complaint investigations. Volunteer visitors are allowed to make routine visits to nursing homes and personal care homes, but must refer complaints back to a certified ombudsman. The Coastal LTCOP began in FY2010 to run local criminal records checks for all volunteers who will be having direct contact with residents as our budget allows.

The Coastal LTCOP will provide recognition events or other recognition efforts for volunteers, as needed and as the budget will allow.

G. Nursing Home Pre-Survey Information

Indicate Program plans related to providing nursing home pre-survey information.

The Coastal LTCOP program target is to provide pre-survey information for 100% of the surveys in the Coastal area for which the program receives timely notice. The Coordinator will retrieve survey information from the State LTCOP and relay it to the staff. In her absence, staff will retrieve the survey information. It is each staff person's responsibility to submit his or her pre-survey form to the SLTCOP by the due date and notify the coordinator that the survey info was submitted. All Coastal Staff will ask for written verification from the SLTCOP of having received pre-survey information.

Other Program Components

Please select at least two of the following:

A. Community Outreach and Education

Indicate Program plans for community education sessions, media contacts (including press releases), exhibits, and/or other outreach activities.

In FY 2012, the Coastal LTCOP will plan to meet the standard of **13** sessions of community education presentations. There are three FTE staff LTCO that will provide a total of 12 sessions and 1 additional session will be conducted by part-time staff.

The Coastal LTCOP regularly participates in health and resource fairs, Chatham County SALT Consumer College and Services to seniors fairs and events. In addition, several community presentations are held to various senior, civic and community groups each year.

B. In-Service Education to Facilities

Indicate Program plans for in-service education to facilities.

C. Family Councils

Indicate Program activities planned related to family councils, including how many nursing facility family councils are currently active in the service area.

D. Interagency Coordination

Indicate Program activities planned related to interagency coordination.

The Coastal Area Ombudsman Program will continue to collaborate with other agency staff as needed. Staff will attend Chatham County S.A.L.T. (Seniors and Law Enforcement Together) and Elder Abuse MDT (Multi-Disciplinary Team) meetings whenever possible to maintain active and on-going involvement in local interagency coordination efforts which relates to ltcf residents. Meetings and/or conference calls for these groups will be attended by the LTCO Program Coordinator at least 3 times during the fiscal year. In addition, the Coordinator has recently accepted positions on the Aging and Disability Resource Center Advisory Committee and the Senior Companion Program Advisory Council.

Advisory Council

Indicate Program activities planned related to a Program advisory council.

Other Activities

Provide any additional information regarding planned program activities (such as special initiatives or projects, or program needs or barriers).

Currently, the Coastal LTCOP has no planned additional program activities.

D. REQUIRED PLANS:

ATTACHMENT D-3 – SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM REQUEST FOR PROPOSAL

Not Applicable

E. AIMS BUDGET DOCUMENTS:

ATTACHMENT E

Title III Federal Allocation and Match Analysis (Separate Excel spreadsheet)

AIMS Area Plan – Budget Fund Source Summary

AIMS Area Plan – Budget Service Summary

AIMS Area Plan – Provider Site List